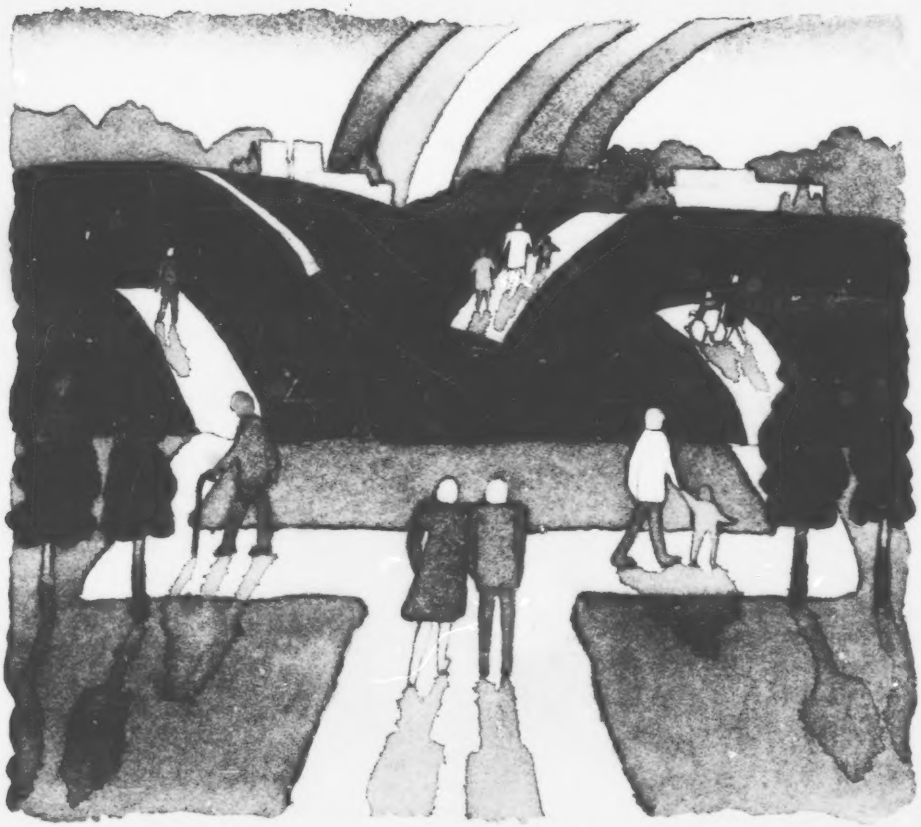
THE RAINBOW REPORT: OUR VISION FOR HEALTH



VOLUME II

PREMIER'S
COMMISSION
ON FUTURE
HEALTH CARE
FOR ALBERTANS

FINAL REPORT
DECEMBER 1989

Your response to **The Rainbow Report: Our Vision for Health** is welcome.

Comment directly to your Member of the Legislative Assembly

or before March 31, 1990 to
Premier's Commission on
Future Health Care for Albertans
17th Floor, 10025 Jasper Avenue
Edmonton, Alberta, Canada T5J 3Z3

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VOLUME ONE — OUR VISION FOR HEALTH

VOLUME THREE — SUPPLEMENTAL INFORMATION

PART FIVE

HEALTHY PUBLIC POLICY

THE DISCUSSIONS, DIMENSIONS & DIRECTIONS

"WHEREAS the fundamental resource of Alberta is its people"...So began the Order-in-Council which established this Premier's Commission on Future Health Care for Albertans, thus setting the tone for our deliberations. Yes, the system is important but only as it serves people. No system can *guarantee* healthy Albertans, living in a healthy Alberta...but a system can support and nurture the personal will of people in pursuit of that achievement.

Volume One of **The Rainbow Report: Our Vision for Health** is comprised of four parts — *The Future, The Commission and the Task, The Rainbow Report and the Recommendations, and The Journey.* These capture the essence of our hopes and visions for the future — through the process of arriving at our conclusions, leading us to the recommendations, and on to the journey that will see them realized.

Volume Two — *Directions for Change* — provides greater detail of the Commission's recommendations and suggestions for implementation. It also contains a summary of the responses to the Commission's Interim Report on Nursing, and a *Glossary of Terms and Abbreviations.*

The roots of the directions for the future as outlined in four major chapters are based in the concepts of "all of us and some of us", and "healthy public policy".

All of us are the people of Alberta. We are the Albertans, and we include some of us who need special support to maintain our health. To varying degrees at some point in our lifetimes, our ability to be independent is impaired — all of us become some of us with the need for specialized care and services. All of us are dependent in infancy, and most of us when we are elderly; some of us require special attention because we have disabilities from birth onward, or as a result of injury or disease. These needs, while different, must be identified and provided for some of us in the same context and values as those for all Albertans…in an atmosphere which encourages self-reliance but recognizes inter-dependence.

We must begin thinking and speaking in terms of health supports needed by some of us, rather than focusing on disabilities and disadvantages. We have tended to *label* some of us who need special support, thereby contributing to our segregation from all of us. It is preferable that such labels be avoided when we are thinking and speaking in terms of people.

Healthy public policy, according to the World Health Organization (1988), is "characterized by an explicit concern for health and equity in all areas of policy and an accountability for health impact. The main aim of healthy public policy is to create a supportive environment, to enable people to lead healthy lives".

The importance of the contributions of health care providers — who have served our communities well in the past and will continue to do so in the future — cannot be overstated. Yet it must be recognized that there are limits to what the health professions can do, or for which they can be held accountable.

The principle behind healthy public policy is a simple one: many of the major determinants of health and disease lie outside the jurisdiction of the health sector, and beyond the control of individuals who might be affected. It is imperative that health and health impact be given priority — or at least as much attention as economic development and diversification, legal and regulatory, and education considerations — on the agendas of those decision-makers who are not involved in health in a seemingly direct way.

To begin, health must be looked upon within an integrated framework of our homes, our schools, our workplaces, and our community environments — both social and physical. The fundamental effect on our health prospects must be taken into account during the determination of public policies. There must be a genuine dialogue between decision-makers and the various publics upon whom the policies will impact. And, this must be followed through with a firm commitment to coordinate activities and resources. This will require the cooperative efforts *among* the three orders of government — federal, provincial and municipal — non-governmental organizations, and the private sector. They must begin talking together and planning together. A tall order? Yes. An unrealistic expectation? No.

The good news is that in Alberta decision-makers and interest-groups are beginning to talk to each other, and — where it occurs — it does work. We still have a long way to go to achieve the ideal, but slowly we are building the foundations that will support healthy public policy development.

Indeed, **Caring and Responsibility — A Statement of Social Policy for Alberta,** produced by the Honourable Neil Crawford in 1988, is an excellent example of healthy public policy, and a clear indication that the Government of Alberta has moved toward the development of such policies. The document "recognizes that social and economic development are inseparable" within its statement of policy, and outlines the role of government in 11 guiding principles (see Appendix, Volume Three). Of the broad range of social programs described in the policy paper, health is the most costly of the four categories listed, consuming almost one-third of the province's expenditures on people-oriented programs and services.

Despite such fiscal prominence, health has yet to attain the profile it warrants as a consideration around government and industry boardroom tables. The establishment of this Commission and the Premier's Council on the Status of Persons with Disabilities are examples of positive steps toward this achievement. Serious consideration should be given to naming ministers to a "Health Board of Cabinet" — similar to the Treasury Board of Cabinet — in recognition of the importance of health matters in all aspects of our lives.

Overall, however, we need improved communications and consultation, and more efficient exchanges of information through the emergence of strong, vibrant networks. By this we mean deep commitment to public participation within communities that identify their own problems, suggest how to solve them, and take the responsibility for doing so. We need coordinated partnerships among various sectors and interest groups to build on a firm knowledge base, using healthy public policy, and health promotion and illness/injury prevention as dynamic forces for change. We need sensitive, progressive governments that understand, facilitate and support this process.

As Albertans — all of us and some of us — want to live in areas where policies and programs are aimed at creating healthier environments. We want to know that the three orders of government are aware of the health implications of their actions at every stage of policy planning and formulation. We want assurance that they will work cooperatively with the private and volunteer sectors to create communities where healthy choices are easy choices. And we want strong emphasis placed on knowledge development and systematic research to deal effectively with these challenges.

Part Five - *Healthy Public Policy* emphasizes, in four chapters, how the Principles of **People**, **Choice**, **Change**, **Decisions** and **Opportunity** can be used to enhance the possibility of achieving the Mission Statement of the Commission.

The first two chapters — **Healthy Albertans: Our fundamental resource**, and **People: The real focus** — are about all of us and some of us, and have people as the core. Firstly, we look at who we are and how we are, and ways to become and stay healthier. Secondly, we examine how we can best relate our overall health to the systems within the health care system.

The next two chapters — **The system: Achieving a balance**, and **The world around us** — focus on broader healthy public policies as the logical means to accomplish our goals. The third chapter highlights building links to produce the best systems we can for the good of both providers and consumers. People have to be able to access services with ease and confidence. The last chapter deals with environmental health issues and the importance of protecting what we have because — in the final analysis — *nothing matters if we can't breathe.*

The following text — *The Recommendations, The General Directions and Six Directions for Change* — for purposes of continuity and emphasis is repeated with minor modification from Volume One.

THE RECOMMENDATIONS

The Commission envisions a health and health care future for Albertans that will serve us well in the Twenty-first Century and still be achievable, believable and meaningful in the context of today.

The recommendations are meant to encourage and motivate…to serve as the impetus for a new generation of commitment and knowledge into which we can move with skill and humanity. Our single most important task is to set ourselves — our minds, our hearts, and our feet — on the journey to our future. If, as Albertans, we choose too narrow a path and explore only our current problems — never venturing down the countless avenues that beckon us on this journey — we will fail.

THE GENERAL DIRECTIONS

The Commission has selected — from among our 21 recommendations — *six directions for change* as demonstrative of the overall approach we have taken. We believe these directions embody the spirit of our conclusions. They are our way of building the future on an essentially sound foundation. Our recommendations are illustrative of the way Alberta can address the short, medium and long-term goals that are identified as desirable. These are elaborated upon in the following pages and presented in greater detail in Volume Two. The recommendations have been numbered for easy reference, and are arranged in an order in which things might happen logically, not in order of importance.

SIX DIRECTIONS FOR CHANGE

"Healthy Albertans, living in a healthy Alberta" can be achieved if the government is prepared to be bold — to demonstrate its commitment to the health of its people as a priority. We need legislation — including a strictly enforced Alberta Code of Health and Environmental Ethics — that ensures that the health of individual Albertans is consciously and publicly in balance with economic development and other initiatives.
(See Page 17, Volume One; and Chapter Four, Volume Two)

Because Albertans are going to be expected to take more responsibility for becoming and remaining healthy, they must develop a greater knowledge-base in healthy living. At a minimum, one per cent more needs to be re-allocated from the total Alberta Health operating budget for specifically targeted promotion and prevention programs.
(See Page 30, Volume One; and Chapter One, Volume Two)

The key to a responsive system is to return the authority for decisions affecting the relevance of health services to people within the communities, familiar with local needs and priorities. Health Authorities, with responsibility for allocating funds and comprised of locally elected trustees, should be established throughout the province.
(See Page 40, Volume One, and Chapter Three, Volume Two)

If the government is committed to fostering an atmosphere of self-reliance, autonomy and dignity among its citizens, then individual Albertans, and/or their designates, should have the responsibility for disbursing and managing the funds required for their health and health care needs.
(See Page 35, Volume One, and Chapter Two, Volume Two)

Matters regarding our lives and our health, and living and dying with dignity are complex and worrisome issues which require deliberation and discussion. The Government of Alberta should provide matching grant funds for the establishment of a publicly accessible Ethics Centre to assist Albertans facing such dilemmas.
(See Page 33, Volume One, and Chapter Two, Volume Two)

The vision of "healthy Albertans, living in a healthy Alberta" needs a champion — an Advocate — to focus on our state of well-being, and the long-term efficiency and effectiveness of our health system. An Advocate for a Healthy Alberta would communicate with and to Albertans and the government about health and health care.
(See Page 38, Volume One, and Chapter Three, Volume Two)

CHAPTER ONE

HEALTHY ALBERTANS: OUR FUNDAMENTAL RESOURCE

WHO ARE WE?

We are the Albertans — all of us — living our lives within families and within communities…fulfilling our roles as parents, children, workers, friends and colleagues, in private and public services to others and ourselves. For some of us, things have never been better or are as good as they can get. For others life is a struggle.

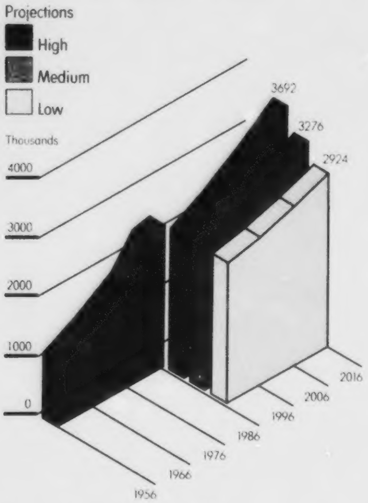
Today, we number 2.41 million people — 1.21 million males and 1.20 million females. Our population has more than doubled since the mid-1950s. Indeed, it underwent a remarkable transformation from 1971 to 1987 when three-quarters of a million people became Albertans — that's equivalent to adding 75 per cent of the people of Saskatchewan or Manitoba to our population. We are projected to grow by as few as a half-million people to as many as one-and-a-half million people in the next 30 years.

The average rate of population growth is expected to be lower in the next, than in the past, three decades. Population growth is derived from natural increase — births minus deaths — and net migration — interprovincial plus international newcomers less persons moving out of Alberta.

Mortality rates have been declining steadily during recent decades — a trend that can be expected to continue largely due to medical and health-related advances that prolong the average lifespan. It is interesting to note that the life expectancy of both males and females increased by approximately three years between 1971 and 1986; that by 1986 the average life expectancy of females was 80.3 years versus 73.3 for males — and projected to rise by 2016 to 83.7 and 78.5 respectively. The difference in life expectancy for males and females has been narrowing since the mid-1950s, and may lessen to an even greater extent in the future, thereby redressing the traditional elderly female-male imbalance. This is critically important because loneliness among the elderly is a major worry for the future — one which caused the Dutch to suggest that maybe younger men should marry older women!

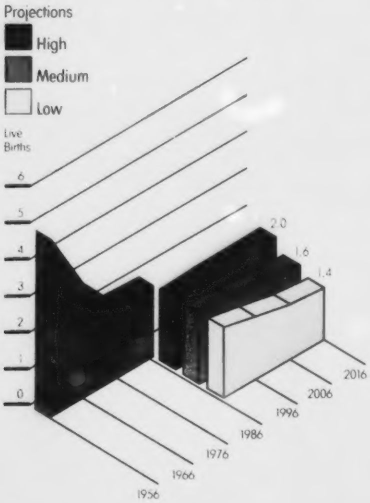
Infant mortality rates have improved significantly as well — from 40 deaths per 1,000 live births in the 1950s to seven in 1987, the lowest rate in Canada. However, fewer Albertans are being born. Fertility rates had dropped from 4.28 births to women 15 to 49 years of age in 1956 to 1.90 in 1986. It is anticipated that the fertility among women between the ages of 20 and 29 prime child-bearing years will decline even further as the "baby boom" generation moves beyond peak child-bearing years. In 1989, there were 745,700 children in Alberta. The projection for the future is that their number will drop to 722,900 by 2001, and to 612,800 by 2016.

Alberta Population, 1956-2016



Source Population Projections Alberta 1987-2016
Alberta Treasury Bureau of Statistics

Fertility, Expected Births Per Woman of Childbearing Years, 1956-2016, Alberta



Source Population Projections Alberta 1987-2016
Alberta Treasury Bureau of Statistics

Migration in Alberta has been relatively conservative, and we generally experience more in-migrants to the province than out-migrants. The extraordinary in-flow of people — 68,300 moved here — attracted by the economic boom generated by unusually high oil activity and prices in the late seventies and early eighties is not projected to recur in the near future. But the Twenty-first Century could herald a new boom to the population as environmental refugees seek out cleaner Alberta air and open spaces.

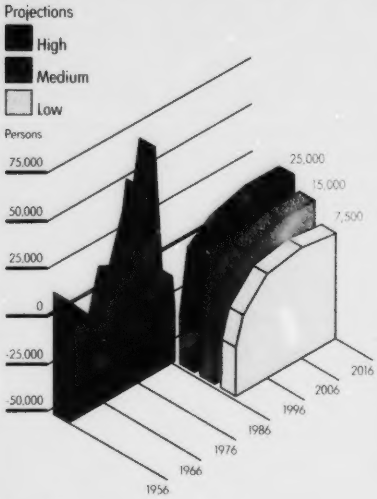
Alberta typically receives between 8.0 and 10 per cent of Canada's overall immigration. The number of new Canadians accepted annually has fluctuated dramatically during past decades, influenced by national quotas and international events which result in decisions to accept refugees — as we did with Vietnamese refugees in the 1970s.

The result is that Alberta has become a diverse cultural mix of people with the greatest proportion of British origin, a substantial number of German, Ukrainian and French origin, and a smaller proportion from other countries.

According to a discussion paper issued recently by Alberta Culture and Multiculturalism, "in 1961, Italy, Britain, the United States, Germany, Greece, Portugal, Poland, Yugoslavia, the Netherlands and France accounted for 85 per cent of the immigrants to Canada. In the 1980s, the top 10 included Vietnam, Hong Kong, India, the Philippines, El Salvador, Jamaica and China. Forty-three per cent of immigrants who arrived between 1981 and 1986 were born in Asia, only 29 per cent came from Europe, compared to 51 per cent in 1961." Because these immigration patterns would be similar for Alberta, the paper suggests that our social and health care institutions face a unique challenge in providing care from a "knowledge which is culturally intuitive, sensitive and accepting". We would do well to apply similar-based knowledge in the provision of care to our Native peoples, as well.

The composition or demographic profile of the population will change considerably in the years to come. Albertan's median age — the point at which half are older and half are younger — was 29 in 1986. From all indications — the aging of the baby boomers, relatively fewer births, and the increase in life expectancy — the median age is projected to shift rather dramatically to between 36 and 40 by 2016. This could be good news for industries that profit from middle-aged spending. The number of 15-to-24-year-olds will drop.

Net Migration, 1956-2016
International plus Interprovincial, Alberta



Source Population Projections Alberta 1987-2016
Alberta Treasury Bureau of Statistics

Percentage Distribution of Alberta's Population by Ethnic Origin, 1981

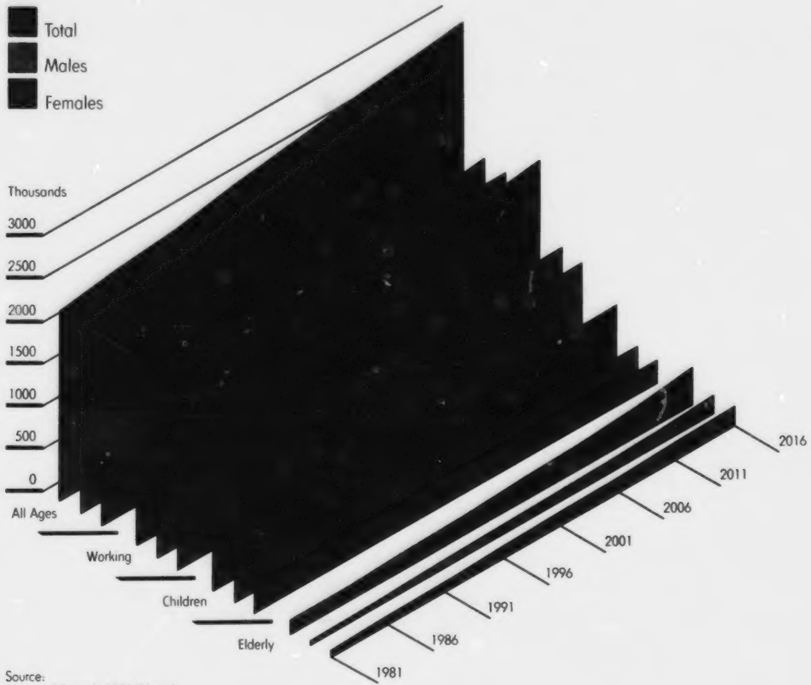
Ethnic Groups	Percentage (%) out of 100
British Single Origins	43.5
German	10.53
Ukrainian	6.18
French	5.05
Scandinavian	3.55
Dutch	2.94
Native Peoples	2.71
Polish	1.70
Chinese	1.56
Italian	1.21
Pacific Islands	.75
Magyar (Hungarian)	.69
Indo-Pakistani	.60
Czech and Slavic	.51
Other Single Origins	6.12
Multiple Origins	12.30

Source: 1981 Census of Canada: 20 per cent Data Base. Statistics Canada. April 25, 1983.

"It is the aging of the population that presents the greatest challenge, since the costs of care for the elderly will need to be supported by a decreasing young population."
The College of Chiropractors of Alberta

Dependent children — those 14 years old and younger — will account for only 17 per cent of the population compared to the current 24 per cent. The decline in the number of young Albertans will mean fewer attending elementary, secondary and post-secondary institutions. The most notable drop in proportion will be those younger than 45 — accounting for 75 per cent of the population in 1986, but only 58 per cent by 2016. In contrast, the elderly 65+ segment will rise from 8.0 to 14 per cent. The fastest growing age segment — Albertans over 80 — will affect health-care delivery and retirement community development.

Alberta Population Projections By Age and Gender



Source:
Census of Canada 1971-86 and
Population Projections Alberta 1987-2016
Alberta Treasury Bureau of Statistics.

These shifts in the age distribution of the population could be cause for concern. While the number of children will stabilize, the proportion of elderly people will more than double — from 201,000 to 464,000 in three decades. The remaining component — the working-age Albertans — will continue to grow at the same rate as the total population. This means 64 per cent of the total population will still be contributing to the wealth of the province…to the support of fewer dependent children and a growing number of elderly citizens.

The strong work ethic

These demographic changes also will affect future labour market developments. In the past, Alberta has experienced average employment growth in the 2.0 to 4.0 per cent range, supported by comparable population growth. The gap between employment growth and working-age population has always been filled by increased labour force participation. In the next 30 years, working age population growth is expected to average only 1.0 to 1.5 per cent — requiring that the gap be filled by continued increases in participation.

The labour force is comprised of the civilian, non-institutional population 15 years of age or older who are employed, or unemployed and seeking or available for work. Labour force participation ratio measures these people against the total population 15 years of age and older. Between 1975 and 1981, Alberta's participation ratio rose by approximately 15 per cent as a greater percentage of the population cashed-in on the economic boom. As the effects of the recession began to be felt, the total ratio held surprisingly firm at the 72 per cent range between 1982 and 1987; however, the gender specific ratios were relatively volatile. The female participation rate grew rapidly between 1975 and 1987 — even continuing to grow slowly after 1982 — while the male rate peaked in 1981 and then gradually fell below its 1975 level.

In 1975, Alberta's total participation rate was 63 per cent — 82.4 per cent male and 49.6 per cent female. In 1987, it had risen to 72 per cent — 81.4 per cent male and 62.7 per cent female. By August 1989, participation rates were at all-time highs — 74.9 per cent overall, 84.6 per cent male and 65.3 per cent female. A record number of Albertans — 1,258,000 — were employed.

It is worth noting that Alberta has traditionally had the highest total participation rate in Canada — in August 1989 the national average was 69.1 per cent while Ontario was second to Alberta with 71.6 per cent. Participation rates should be considered far more important than unemployment rates — they mean hope, not despair. Were our participation rates not so high, our unemployment rates would be lower. Albertans want to work…and most of us do. And the rest of us who are out there looking strongly believe we will find employment.

Participation Rate by Gender and Age, Alberta

	August 1989		
	M	F	M+F
15-24	87.6	79.6	83.7
15-19	81.7	72.6	77.3
20-24	93.4	86.0	89.7
25+	83.9	61.7	72.6
25-44	96.9	77.9	87.4
45-64	84.7	58.7	71.8
65+	17.6	4.2	10.1
Total	**84.6**	**65.3**	**74.9**

Source: Alberta Bureau of Statistics, 1988

Employment/Population Ratio by Gender and Age, Alberta

	August 1989		
	M	F	M+F
15-24	78.5	72.0	75.3
15-19	70.3	65.1	67.4
20-24	86.3	78.9	82.6
25+	79.8	56.6	68.0
25-44	91.9	70.6	81.3
45-64	80.7	55.7	68.3
65+	17.6	4.6	10.4
Total	**79.5**	**59.7**	**69.5**

Source: Alberta Bureau of Statistics, 1988

"It is recommended that, in view of the healthy public policy, unemployment issues will need consideration because of the cycle of unemployment, poverty, social and health issues. Employment opportunities will need to be available for the aging population and disabled."
Wetoka Health Unit Board.

"...First, we make little provision for phasing-in retirement with the option of continuing some years of productive part-time employment both for men and for women. Having something to do, and having someone to do it with, having a contribution to make to society is part of the personal well-being and holistic health of any able-bodied person."
Senior Citizens Workshop Participant

"It is recommended that there be more interpreters in our medical centres who could help overcome the language barriers and also provide some much needed psychological insight. People with some expertise and training in their native land could gain some recognition here by being 'lay assistants' to our professionals just as the 'barefoot' doctors were in China."
A.L. Davies-Fuhr

As more Albertans elect to take early retirement, this too will affect labour force participation rates. In the first year following the January 1987 changes to the Canada Pension Plan — allowing retirement from age 60 at a reduced pension — twice the number of Canadians retired before age 65. This trend could be reversed. Rules and policies could be changed by the federal and provincial governments allowing older workers who are healthy to continue working and contributing to the revenue base — either because of a Supreme Court ruling against mandatory retirement, or to fend off the increase in social services costs that can be anticipated as the baby boom generation nears retirement.

As Alberta's population ages and there are fewer 20 to 24 year-olds, job opportunities may increase for teenagers. The long-run social consequences of more teens holding full and part-time jobs is unclear, but early employment could interfere with educational attainment. Another subtle impact is that young workers are at highest risk for work-related injury. Communicating with them regarding occupational health and safety practices will become increasingly important. The "catch-22" could be in attempting to effectively communicate with young people who have limited their literacy and numeracy skills to become wage-earners. This is particularly important to being healthy — a condition linked to education and income levels.

Shortages in Alberta's labour force could be partially or totally offset by encouraging increased immigration. The majority of recent immigrants have found employment in the services, manufacturing and trade industries. While 86 per cent of immigrants have a grade nine or higher education, compared to 60 per cent of Canadians, many are working in jobs other than those for which they were trained in their countries of origin — often because they lack proficiency in the English language. As new Canadians begin to form a larger percentage of the population, effective ways to communicate with them about health and health care will become increasingly important. Indeed, the matter of communication is critical to all Albertans. The problem of illiteracy — both among new Canadians and our native born population — is frightening. Twenty-two per cent of Canadians over the age of 15 and not attending school is illiterate or functionally illiterate. Participation by Canadians aged 17 in formal education and apprenticeship programs is 74 per cent, compared to 94 per cent in Japan and 89 per cent in Germany.

Literacy and comprehension are linked to health. If one doesn't understand, how can one respond to suggestions? *It may be that the most important dollar spent on health is the one spent on education.*

The spectre of poverty in the midst of above average incomes

Income level is a determining factor in the lifestyle and health needs of Albertans. There appears to be an undeniable link between how much money we have and our state of well-being. Speaking at the International Conference on Health Promotion in 1986, then-minister of Health and Welfare Canada, Jake Epp, said that "the first challenge we face is to find ways of reducing inequities in the health of low-versus-high-income groups in Canada...despite Canada's superior health service system, people's health remains directly related to their economic status. For example, it has been reported that men in the upper-income group live six years longer than men with a low income." In 1969, 23 per cent of Canadians were identified as "poor"...and while that percentage has now been halved, more must be done to improve income levels.

The matter of how to deal with poverty in Canada, and within various regions, has been the subject of many studies. The concept of guaranteed annual income formed part of the Saskatchewan Family Income Plan (1974); Ottawa's Child Tax Credit Plan (1978); Quebec's Work Income Supplement Program (1979); Manitoba's Income Support Program (1980); and the Macdonald Commission's Universal Income Supplementation Program (1985). The question of guaranteed annual income as a substitute for the many federal and provincial social assistance programs will not go away until it can be shown that a separate guaranteed income scheme is **not** more efficient, effective, and economically — as well as more socially — acceptable than the multitude of universally available social programs now in place. What seems to be needed is the national will — followed by the political will — to help poor, including working poor, Canadians with more than just money. These people need sympathy, understanding, and kind direction. We must encourage more programs — like the one for the people in Calling Lake in northcentral Alberta — which attempt to reverse community dependency on welfare through an action plan that includes providing funds for a liaison worker, plus job and economic development combined with social assistance reform.

"Poverty has a major impact on health and is often seen in the groups of single mothers, low-income families and families caring for a sick member. Poverty affects one's ability to obtain health for themselves and their families."

The Alberta Community Health Nurses Society.

Edmonton Food Bank

"The health care system is picking up the deficiencies in Canada's distribution of income, housing and its social system in general...Incomes should be raised at least to the equivalent of the poverty line."
Alberta Association of Social Workers

"It is recommended that issues such as equal pay, women's rights, children's rights, plight of the single parent...will need to be addressed on a broader context."
Medicine Hat Regional Psychiatric Services Planning Committee

Generally, average incomes in Alberta increased significantly during the boom years of the seventies, fell with the onslaught of the recession in the early eighties, and have improved from 1985 onward. The average family income in 1986 was $42,428 — 5.1 per cent higher than the average for Canada. The Statistics Canada 1988 estimates for personal income per capita were $19,898 in Alberta, compared to $19,509 for Canada.

Personal Income; Alberta 1971-1988

Year	Total Personal Income ($M)	Annual Change (%)	Total Population (000's)	Annual Change (%)	Personal Income Per Capita ($)	Annual Change (%)
1971	5501	–	1628	–	3379	–
1972	6289	14.3	1657	1.8	3795	12.3
1973	7501	19.3	1690	2.0	4438	17.0
1974	9127	21.7	1722	1.9	5300	19.4
1975	11064	21.2	1778	3.3	6222	17.4
1976	12787	15.6	1838	3.4	6957	11.8
1977	14573	14.0	1913	4.1	7618	9.5
1978	17262	18.5	1983	3.7	8705	14.3
1979	20545	19.0	2053	3.5	10007	15.0
1980	24688	20.2	2141	4.3	11531	15.2
1981	30763	24.6	2237	4.5	13752	19.2
1982	34692	12.8	2315	3.5	14986	9.0
1983	35451	2.2	2339	1.0	15156	1.1
1984	36796	3.8	2339	-0.0	15732	3.8
1985	40523	10.1	2349	0.4	17251	9.7
1986	42220	4.2	2375	1.1	17777	3.1
1987	43799	3.7	2380	0.2	18403	3.5
1988	47774	9.1	2401	0.9	19898	8.1

Source: Statisics Canada, Catalogue No. 13-201, 13-531 and 91-210

Despite our apparent prosperity, poverty is a reality for a substantial number of Albertans...and because of higher income levels, the gap between those who "have" and those who "have not" is wider here than elsewhere in Canada. Low income is defined as having to spend 58.5 per cent of one's income on the essentials such as food, shelter and clothing. However, because few can agree on where "the poverty line" really lies, poverty is a relative concept.

Certain groups are particularly vulnerable to poverty: one-parent families — four in 10 headed by women in Canada are poor compared to one in 10 headed by men; unattached persons — women more so than men; unattached elderly persons — again women more so than men. Such phenomena identify the trend that has been termed the "feminization of poverty" — an over-representation of women in the ranks of those living on low incomes. Fortunately, the feminization trend did not accelerate in the eighties; and poverty has declined significantly for elderly Albertans, particularly those who live in families. Poverty among unattached senior women, notably widows, remains a serious problem.

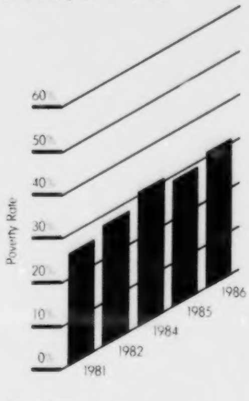
Children are the unwitting victims of low income. In 1986, 93,600 — 15.6 per cent — of Alberta's children under the age of 16 were living below the poverty line. The impact on their lives and their well-being is significant — the further tragedy is that poverty tends to perpetuate itself through generations. Once caught in the web of ill health, generally poor nutrition and low education, the chances of escaping to attain a healthier state of well-being are lessened.

The risk of poverty is clearly linked to education levels — generally, the higher the education of the head of the family, the higher the income levels, and the healthier the family. This should not be interpreted to mean that Albertans living above the poverty line are immune to ill-health, malnutrition or poor educational attainment. New diseases of affluence — addiction to alcohol and other substances, and undernourishment and poor physical condition as a result of time-constraint or addictive behaviour — are a growing concern.

We must nurture and protect our children — our most valuable resource. As parents we must know how to care for children, and encourage an active partnership with them in learning about health and how to assume responsibility for making healthy choices. Our homes, and educational and social environments in Alberta must be maintained in a manner that will nurture the intellectual, physical and psychological development of our children. Children are our hope...our future.

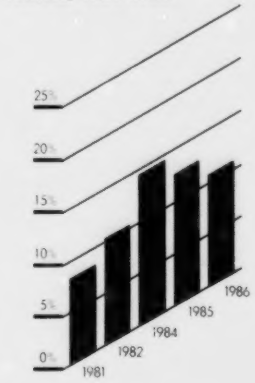
We have provided a statistical sketch of Albertans. Some of these numbers and projections may be difficult to comprehend or to put into perspective at a personal level. Quite simply, they are presented to help us understand the health challenges we will face as a result of growth and the changing face of our province.

Percentage of Unattached Individuals Below the Poverty Line, Alberta, 1981-1986



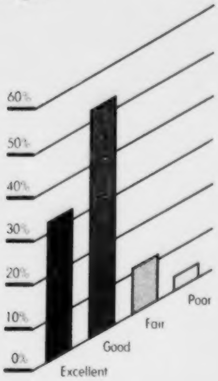
Source Poverty Profile 1988
National Council of Welfare Canada 1988

Percentage of Families Below the Poverty Line, Alberta, 1981-1986



Source Poverty Profile 1988
National Council of Welfare Canada 1988

Self-Rated Healthiness Among Albertans: For Both Genders and All Ages



Source: Health and Welfare Canada 1985 Survey

HOW ARE WE?

The health status — health report card — of Albertans definitely is improving. Furthermore, we really believe we are healthy — 86 per cent of us rated our personal healthiness at excellent or good in 1985. Only 4.0 per cent of us saw ourselves in poor health compared to our peers; the balance of us felt our health was fair.

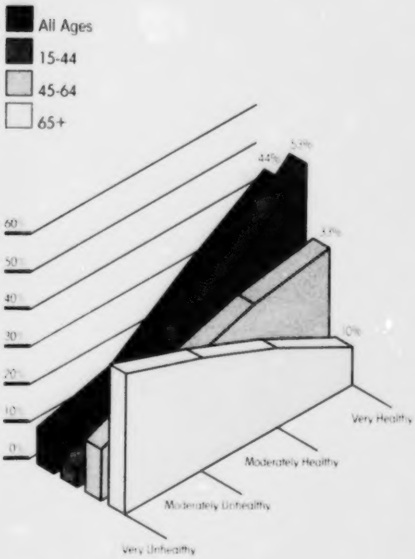
These statistics were collected through a health survey conducted in 1985 by Health and Welfare Canada. The purpose of the survey was to get an idea of how Canadians viewed their health, as well as their attitudes, practices, and actions in regard to staying healthy.

One of the criticisms often levelled at health status reports is that measures of health and well-being are absent and only measures of illness and death are available. To a large degree, the health care system does not typically collect information about how healthy we are, but about how ill we are. Often, the health of populations is determined by surveys of various groups. They allow an overall assessment of health status compared to fragmented accounts of particular problems which scientifically analyze the occurrence of illness and death. They provide a glimpse of health, illness, and disease that is not usually captured in the health care system's routine reporting activities. They give prominence to the personal element of health — how we perceive our own health — and provide a starting point for planning health programs that call for individual action. The success of these actions, however, depends on personal attitude and commitment.

Based on the findings of that 1985 health promotion survey, most of us feel pretty good about ourselves. Only about 5.0 per cent of us between 15 and 44 years of age reported that we were very unhealthy. However, the older we get, the more unhealthy we feel. Among the 45 to 64 year-old age group, 14 per cent categorized ourselves as very unhealthy. Almost 40 percent of us over 65 years of age self-evaluated our condition as very unhealthy.

It is interesting that so many of us rate ourselves as healthy — perhaps because we are not ill. Yet how many of us who believe we are healthy really think we are as fit as we are healthy? Nor does the absence of illness necessarily equate with being in a state of complete well-being — physically, mentally and socially.

Healthiness Index by Selected Age Groups of Albertans



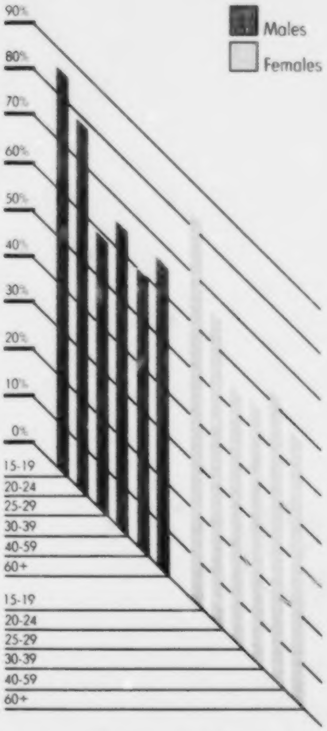
Source: Health and Welfare Canada 1985 Survey

Indeed, it seems that Canadians, on the whole, are striving for better health. Based on the national data, 64 per cent of Canadians — most of whom assessed themselves as healthy — are determined to do more to improve their health and fitness. They have set personal goals to exercise more, improve eating habits and lose weight, and quit smoking.

In Alberta, more than 80 per cent of males and females in the 15 to 19 year-old category exercise at least three times per week. Among Albertans aged 60 and older, 65 per cent of males and 57 per cent of females exercise regularly. In fact, more senior males participate in fitness activities than those in the 25 to 29 year-old group. The marked decrease in physical exercise among both sexes after age 25 should be a matter of concern. Not until Albertans reach middle age does exercise again become a routine practice.

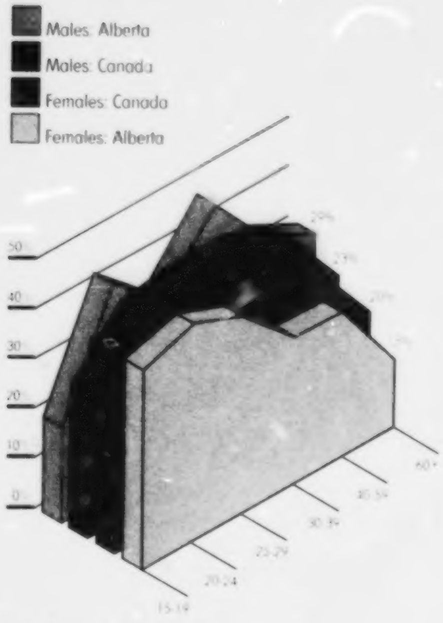
Alberta has begun describing itself as the "Fitness Capital of Canada" — Calgary boasts more fitness centres per capita than any other city in the country. Strenuous exercises such as aerobics, squash and racquetball are becoming more and more popular as lunch-hour and after-work activities. Greater numbers of Albertans are riding their bikes or walking to work… running and jogging for themselves and to raise funds for charity. Other evidence of the growing trend toward personal fitness is in the proliferation of health food and diet centres, and bottled water companies during the past few years. Managing stress has become increasingly important as people of all ages attempt to deal with difficult situations in the homes, workplaces and schools. As well, more and more companies are realizing that a fit employee is a productive employee — both the private and public sectors have indicated their interest in initiatives which will promote fitness and healthy lifestyles.

Percentage of Albertans in 1985 Who Exercised Three or More Times/Week



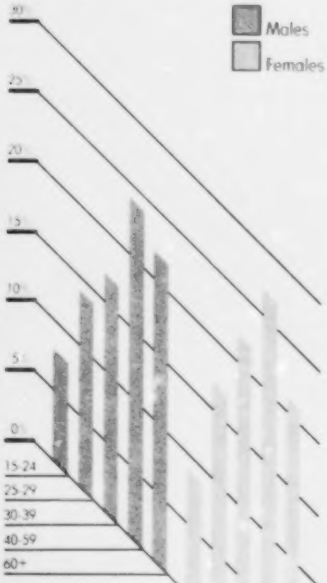
Source Prepared by RPM Assoc Ltd 1989

Percentage of Albertans and Canadians Who Were Regular Smokers in 1985 by Age



Source: Prepared by RPM Assoc. 1989

Percentage of Albertans Who Were Overweight in 1985 by Age



Source: Prepared by RPM Assoc. Ltd. 1989

Despite our new-found interest in health and fitness, our personal habits don't always support our aspirations to be healthy. One in three Albertans surveyed in 1985 were smokers. Worst were teenage girls — 40 per cent smoke — more than twice the percentage of boys, and at least 10 per cent higher than the national figure. Further, 11 per cent of males and 5.0 per cent of females were heavy drinkers. More than half of us admitted we needed more exercise, and 17 per cent were significantly overweight.

In the health promotion survey, seven out of 10 of us indicated we should do something to improve our physical health, and 29 per cent of us want to do something to improve the way we cope with stress. Positive habits have become a social expectation for many Albertans. In terms of self-care selected health practices, a significant number of Albertans are engaged in what could be called "health-seeking" behaviours. Unfortunately, those of us who rate our health as poor are the least likely to take the time, trouble and effort to pursue such positive behaviours.

Having commented on the importance of health promotion by individuals, some further comments are warranted regarding public approaches by governments, industry and organizations. Awareness of the negative health impacts of smoking have resulted in "no smoking" bylaws, smoke-free buildings, quit smoking programs, and increased taxes on tobacco products. It is interesting to note that the federal budget for anti-smoking campaigns in 1989-90 is estimated at $1.4 million. The federal budget for tobacco research at Delhi, Ontario — where 95 per cent of Canadian research in tobacco takes place — is set at $1.4 million for 1989-90. Federal revenue from taxes levied on tobacco products in 1988 was $4.5 billion. Such observations are not lost on a population which watches closely what governments do, and listens intently to what governments say.

WHAT AILS US AND HOW DO WE DIE?

Although overall improvements to our well-being are reflected in a longer life span, the number of years of one's remaining life likely to be spent in an unhealthy state is increasing. It is currently estimated that at age 15, of the remaining potential 60 years of life, only a total of three years — 5.0 per cent — is likely to be spent in ill health. But by age 65, it is conceivable that about two — 20 per cent — of the remaining 10 years may be spent in illness.

Among the adult population, the leading causes of death in male Albertans between the ages of 20 and 64 are cancer, heart disease, suicides, and motor vehicle accidents. In females, cancer, heart disease, suicide and motor vehicle accidents are at the top of the list in that order.

Seven Leading Causes of Death by Age & Gender
Alberta - 1988

	Heart Diseases	Malignant Neoplasms (Cancer)	Cerebrovascular Disease (Strokes)	Accidents & Adverse Effects	Chronic Obstructive Pulmonary Disease	Pneumonia and Influenza	Suicide	Total	Seven Leading & All Other Causes of Death
All Ages									
Male	2275	1902	432	354	140	278	305	**5686**	**7918**
Female	1658	1581	579	112	79	214	94	**4317**	**6059**
Total	3933	3483	1011	466	219	492	399	**10003**	**13977**
19 and Under									
Male	2	18	1	88	4	3	35	**151**	
Female	3	8	1	24	0	6	3	**45**	
Total	5	26	2	112	4	9	38	**196**	
Age 20-64									
Male	348	615	56	234	17	30	246	**1546**	
Female	90	592	46	64	23	17	80	**912**	
Total	438	1207	102	298	40	47	326	**2458**	
65 and Over									
Male	1925	1269	375	32	119	245	24	**3989**	
Female	1565	981	532	24	56	191	11	**3360**	
Total	3490	2250	907	56	175	436	35	**7349**	

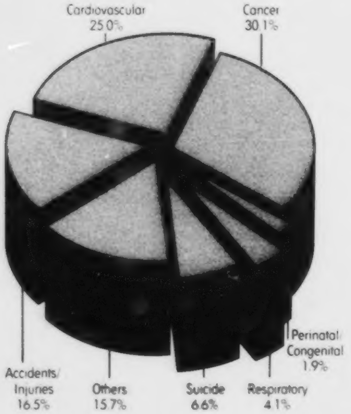
Source: Alberta Vital Statistics

Although the death rates have been declining for all diseases, there is a gender shift in the incidence of lung cancer — the rate of occurrence in males is declining, while the rate in women is on the increase. Between 1980 and 1986, the number of Albertan women with lung cancer doubled. The connection between smoking and lung cancer does not seem to be getting through to women…or to teenaged girls.

In 1987, there were 5,520 deaths of Albertans aged 70 years and less. Cancer accounted for 30 per cent of those deaths. Cardiovascular disease, a category which includes all coronary and cerebral vascular diseases such as heart attacks, strokes, and diseases of the arteries, accounted for 25 per cent of the deaths. Accidents and injuries accounted for 16.5 per cent.

Death in itself is generally viewed with sadness, but when we consider that as many as half the deaths in Alberta are categorized among the seven causes termed "preventable", it gives us an even greater sense of loss. The potential years — tens of thousands of years — of life lost represent a tremendous and tragic loss to families, to communities and to Alberta society as a whole.

Distribution of Mortality by Cause, Both Sexes. Age 70 Years and Under. Alberta 1987.



Source: Alberta Health

Alberta, 1987
Selected Causes of Death and Potential Years of Life Lost (PYLL)
Ranked by Number of Deaths of People 70 and Younger

	Total Deaths	%	Deaths/ 70 and Younger	%	PYLL (70 Yrs)	%
Cardiovascular Disease	5396	40	1378	25	15524	13
Cancer	3311	25	1664	30	22747	19
Respiratory	1081	8	229	4	4202	3
Accidents/Injuries	1139	9	909	16	34392	28
Digestive System	504	4	219	4	3372	3
Other	500	4	199	4	7442	6
Suicide	388	3	364	7	11677	10
Endocrine	285	2	112	2	2101	2
Nervous System	257	2	103	2	2554	2
Mental Disorders	192	1	73	1	1399	1
Congenital Anomalies	138	1	126	2	7883	6
Perinatal Period	112	1	107	2	7276	6
Infectious	84	1	37	1	941	1
Total	**13387***	**100**	**5520**	**100**	**121510****	**100**
Infant Mortality for Selected Causes	326	2			22657	19

*(Non-Residents Included in Total Number of Deaths)
**Indicates Potential Years of Life Lost had these individuals lived to at least 70 years of age

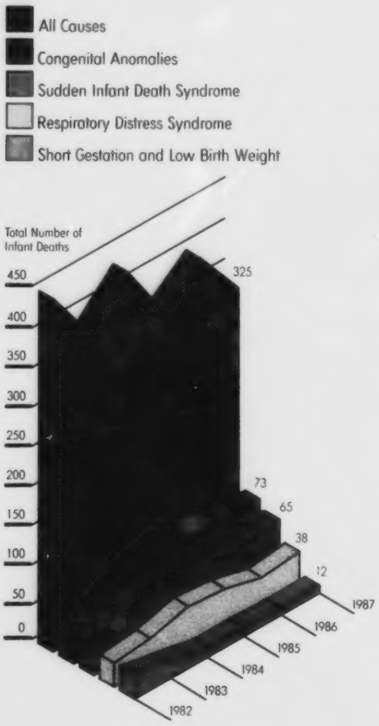
Source: Alberta Health 1988

There are specific challenges associated with certain age groups. In the case of infants under one year old, the challenge is to encourage good prenatal care and breast-feeding — increasing chances of having a healthy baby. Teenagers must be more sexually responsible and understand the dire consequences of pregnancy during adolescence. Although infant mortality declined between 1982 and 1987 by 27 per cent — from 445 to 325 — in 1987, 13 per cent of the infants born to females age 15 were of low birth-weight — a condition associated with ill health and death in newborns.

The leading cause of death among our one to 14 year old children is accidents. Many of our one to five year-olds die in accidental falls in the home. Our six to 14 year-olds — 74 per cent of them between 1983 and 1986 — died in motor vehicle accidents, often involving bicycles.

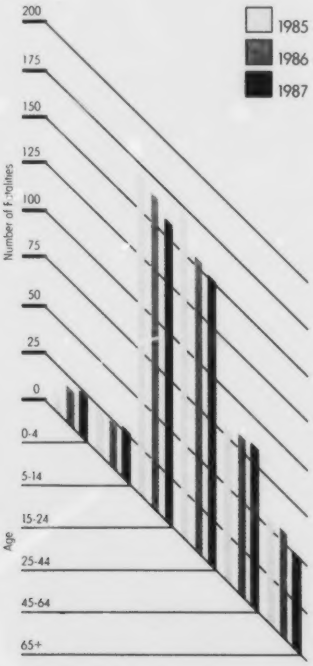
Among young Albertans, aged 15 to 24 years, the two leading causes of death are motor vehicle accidents and suicides. Between 1983 and 1986, motor vehicle fatalities accounted for 60 per cent of the deaths of males, and 68 per cent of the deaths of females. In 1987, 79.4 per cent of the teenaged boys and girls, and 82.2 per cent of the 20 to 24 year olds who died were involved in motor vehicle accidents.

Trends in the Causes of Infant Mortality in Alberta



Source: Prepared by RPM Assoc. Ltd. 1989

Motor Vehicle Fatalities Alberta 1985-1987



Source: Conference 1989 — Injury in Alberta
Injury Awareness & Prevention Centre
University of Alberta

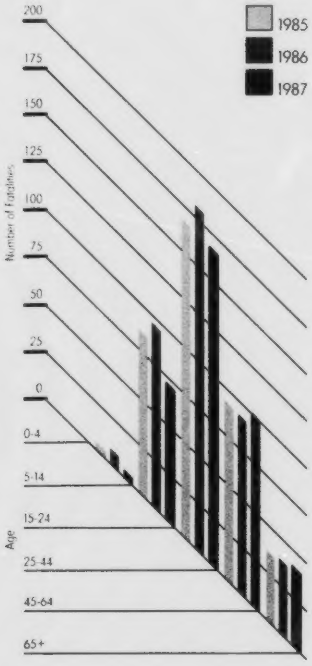
> **"...I believe that the key place where one develops his/her values is in the home from those that are in the family. I would even dare to say that family/upbringing has more to do with a healthy or unhealthy attitude more than anything else. For example, if alcohol abuse is exhibited by the parents in the home, I would imagine that the children would have more of a tendency to do the same more than a child that has been brought up by parents who do not abuse or even use alcohol. I also believe that suicide prevention starts in the home. As far as I can tell, it would be highly unlikely for one to commit suicide if he/she has been brought up in a stable, loving and caring environment. Therefore, I believe that a greater emphasis should be put on strengthening the family than has been placed in the past."**
>
> **"...I believe that more media information (television, radio, and magazines especially) relating to health awareness would benefit society. I do not believe that I would recognize the gravity of the problem of drunk driving as greatly as I do if the media had not presented as much information as it has in the past. Media can help develop public awareness whether it deals with AIDS, drunk driving, suicide, teenage pregnancy or any subject of concern."**
>
> Youth Workshop Participants

It should come as no surprise to Albertans that many of these motor vehicle accidents can be associated with alcohol consumption. And no wonder! There were 1.79 million vehicles registered in Alberta in 1988 — the highest number in all the provinces. There were 3,400 licensed drinking establishments in Alberta in 1988 — the province with the highest per capita alcohol consumption in Canada. There were 18,000 impaired driving charges laid against motorists in Alberta in 1988 — the highest drunk-driving rate in the country.

An alarming number of Albertans take their own lives. In 1988, reported suicides accounted for 312 deaths of males, and 95 deaths of females.

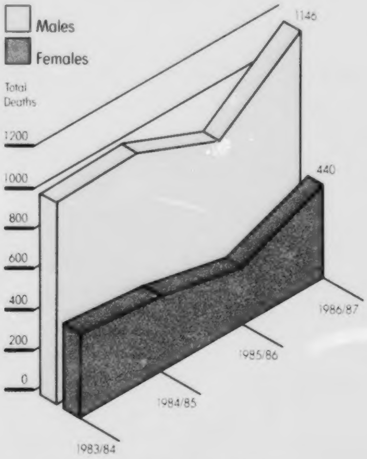
It is believed that a significant number of lethal and disabling injuries, caused by motor vehicle accidents, could have been prevented had precautions been taken by the victims. The Injury Awareness and Prevention Centre at the University of Alberta has developed a program aimed at teenagers in an attempt to jolt them into realizing the value of safety on the road. The incidences of deadly and debilitating head and spinal cord injuries could be markedly reduced by practices such as the use of seat belts and helmets, correct safety procedures, and timely first aid.

Suicide Fatalities
Alberta 1985-1987



Source Conference 1989 — Injury in Alberta
Injury Awareness & Prevention Centre
University of Alberta

Injury Deaths (Alberta 1983-1987)
Alberta figures do not inlcude non-resident deaths in Alberta



Source Catalogues 84-203 Causes of Death — Vital Statistics
Volume IV Statistics Canada, 1983/84 - 1986/87

Pregnancy among teenaged Alberta girls is a serious concern. The rates of both pregnancy and abortion in Alberta exceed the national average. The therapeutic abortion rate for young women aged 15 to 19 has remained relatively constant since 1974, peaking to 23.6 per 1,000 in 1980, but declining to 18.1 per 1,000 in 1984. This might be due to a lack of counselling and support services for young women who are seeking abortion in Alberta. There are family programs that provide professional counsel to assist with clarification of alternatives for young pregnant women. Some physicians deal sympathetically with women who are exploring alternatives, but access to such physicians is not systematized and, in many areas of Alberta, is not available.

Abortion is only one aspect of what the Edmonton Board of Health identifies as a problem in respect to Alberta's reproductive health status, evidenced by the increase of sexually transmitted diseases, and abortion rates in young females.

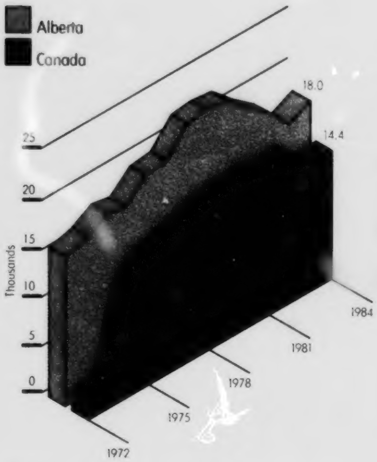
Sexually transmitted diseases (STDs), which include chlamydia, syphilis, gonorrhea, HIV and AIDS, were diagnosed among about 20,000 Albertans in 1988. The highest risk-groups are females between 15 and 19 years of age, and males between 20 and 24. Frequency decreases among older age groups.

Some of the diseases are almost symptom-free and may go undetected for months or years, but all are easily transmitted by sexual contact. Effects range from discomfort to pain, serious complications to consequences for future reproductive health, and even to death.

Without downplaying the seriousness of STDs, the Sexually Transmitted Diseases unit of Alberta Health indicates that the rate of incidence may appear higher than in the rest of Canada because of our thoroughness of surveillance and the fact that almost 100 per cent of cases are reported.

Both public health units and schools are making a concerted effort at providing information and counselling to students in particular. Classes on human sexuality are being taught from grade four through high school in most systems in the province.

Therapeutic Abortions per 1000 Women Aged 15-19 (1972-1984)



Statistics Canada, (1982, 1984) Catalogue 82-211
Alberta Hospitals & Medical Care
Health Economics & Statistics, 1985

Sexually Transmitted Disease Cases in Alberta

	Gonorrhea		Other STDs	
Age	Female	Male	Female	Male
15-19	718	336	2339	NA
20-24	691	778	2665	2120
25-29	287	498	1074	1503

Source: Alberta Health 1989

"It is recommended that sex education for adults, teenagers and children is vital. In this era of increased sexually transmitted diseases people require more detailed information about birth control methods as well as their own sexuality."

The Alberta Advisory Council on Women's Issues

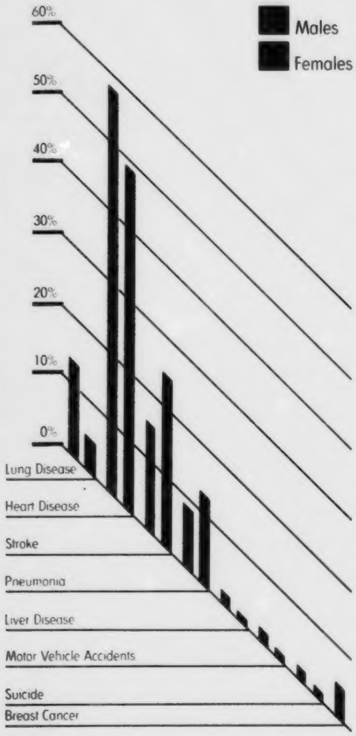
"With an effectively coordinated and integrated mental health care system, and with an emphasis by all parties on fostering mental health, it should be possible to do much more effective work in the area of prevention; costs and needs for services would, we believe, dramatically decrease over time."

Margaret A. Shone and
Shirley Forbes

The Child and Adolescent Services Association brought to the attention of the Commission some startling statistics about children in Alberta. In 1981, more than 10,000 children ran away from home. That year 5,000 children were in the care of the provincial government, many of them in foster homes. Recent studies indicate that 80 per cent of welfare children have serious mental health problems. Child abuse — still on the increase — is a major problem. The number of juvenile offenders — 85 per cent of whom were below the appropriate academic level in school — has risen five-fold. Twenty per cent of the inmates in Alberta's correctional institutions were only 19 years old. One in 10 of our children has a learning disability, and as many as 20 per cent of elementary school children have speech impediments. An incredible 84 per cent of grade 12 students consume alcohol...42 per cent use marijuana, and 12 per cent hallucinogens. Almost half of our high school students have used hashish. Suicide is the second leading cause of death among teenagers — the rate has increased 12 times since 1951. Among Native youths, the rate is five times the national average.

These disturbing statistics point to the serious problems — particularly in the mental health area — of our young people. Yet the last major funding initiative for child and adolescent mental health occurred in the 1960s with the opening of the Glenrose Child and Family Psychiatry Unit and the Westfield Child Welfare Facility. Since then, despite a significant increase in the population and evidence of these unhealthy trends, no major resources have been committed to children's mental health. Indications are that during the next 20 years, greater needs will be identified. Alberta children are crying out for help. The challenge is to provide them with our understanding and guidance.

Causes of Death of Albertans Aged 65 and Over



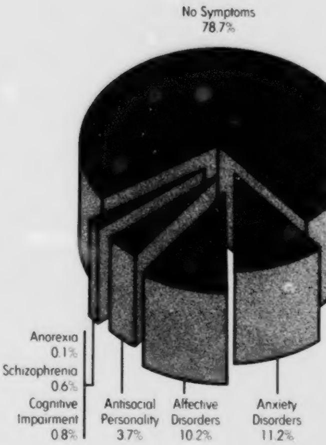
Source: Prepared by RPM Assoc. Ltd. 1989

The Commission views as extremely positive the establishment of the $200 million endowment for the Family Life and Drug Abuse Foundation, announced in the 1989 Speech from the Throne. The intent of the Foundation is to strengthen Alberta families through the promotion and coordination of programs and research directed at enhancement of family life and the identification of factors affecting the stability of families including the prevention and treatment of drug abuse.

In the seniors group, the leading causes of death are heart disease, strokes, pneumonia and lung disease. These trends have been declining for all diseases except pneumonia which has increased by 3.0 per cent. This increase is probably due to the fact that pneumonia is a complication during recovery from any serious condition — many of which may have caused death previously but now are treatable. In females, heart disease is followed by stroke, pneumonia, breast cancer, and lung cancer as causes of death. Seven out of 10 Albertans, like other Canadians who were 65 years or older, had some degree of long-term activity limitation.

Older people are particularly vulnerable to depression because of loss of income, power and status; physical losses due to declining health, and painful chronic debilitating illness; or personal losses such as the death of a spouse. Compared with other age groups, people aged 50 and over have the highest rate of completed suicide. Often, suicide is disguised as drug overdosage, lethal drug and alcohol mixture, failure to take life-sustaining medication, or starvation.

Nature of Mental Disorders In the General Population



Source: Bland, Orr & Neuman 1987.

There are approximately 300,000 Canadians living with Alzheimer's disease or other related dementias. About 10 per cent of our senior citizens suffer mild to moderate dementia; 5.0 per cent from severe dementia. Because the incidence increases with age, close to 20 per cent of those over age 85 may be affected. Some forms of dementia or states of confusion — caused by illness, inappropriate medication or situational depression for example — are reversible. If not treated correctly and promptly, permanent damage can result.

According to Statistics Canada, one of every eight Canadians can expect to be hospitalized with mental illness. Its researchers estimate that "between 10 and 30 per cent of the population have some form of mental illness depending on the definition of the disorders..." In Alberta, 200,000 people receive some level of mental health care. Of this total, 24,000 persons are considered chronically disabled and may require long-term care as opposed to care within the community or acute care facilities.

Particular problems affect the well-being of Natives, but it is very difficult to derive separate statistics on the general health of the Native population in Alberta. Studies done elsewhere in Canada give some indication of relative changes in the causes of death that can be considered relevant to Alberta. While there has been a significant improvement in the general physical health status of Natives, it still lags behind that of non-Native Canadians. For instance, the rate of tuberculosis decreased significantly during the past 50 years, but among Natives it remains seven to 10 times the national rate, although there now are few deaths due to tuberculosis.

"It is recommended that other provincial health oriented agencies, such as AADAC and public health units, have personnel who can work effectively with native people and who appreciate their background and culture."
Grey Nuns of Alberta

It has been estimated that between 22 and 38 per cent of Native deaths in 1987 were the result of accidents and violence compared to 9.0 per cent for the rest of the population. The problems of alcohol and other substance abuse, and poor health practices and living conditions associated with low incomes are cause for serious concern. Additionally, both fertility rates and infant mortality rates are higher. Too often, we receive news reports of suicides by young Natives who have been placed in foster home settings. Overall, Native suicide rates are six times the national average. Adjustment to urban or different environments is particularly difficult for many Natives who cannot cope with being separated from traditional supports within their own communities.

HOW DO WE GET HEALTHY AND STAY HEALTHY?

This chapter deals with health promotion and reduction of preventable disease and injury. In discussing health promotion and illness/injury prevention, a section dealing with health information, education and awareness is presented.

From the outset, we acknowledge that virtually everything seems to have been said before. The problem does not seem to be in knowing what to do, it is in getting it done!

One of the reasons that little seems to really get done about health promotion and illness/injury prevention today is because much of it was done for our society in the past. Success, in this case, did not breed success.

In the first decades of the century, the big killers were natural disaster, infections during infancy, and infectious diseases such as tuberculosis, diphtheria, cholera and smallpox. Deaths of men and women in their forties were not considered unusual. Many of us remember brothers and sisters dying at birth or in infancy. Pneumonia was called "the old person's friend", and the influenza pandemic of 1918-19 claimed 20 million lives world-wide. Public health measures have been enormously effective in attacking the problems of infection and contagion. Professor George Albee of the University of Vermont may have expressed the importance of population-wide health promotion and illness/injury prevention best: "No mass disorder or condition affecting humankind has ever been eliminated or controlled by treating afflicted individuals."

But we now die of heart disease, cancer, stroke, accidents (principally automobile-related), cirrhosis of the liver, and diabetes. The causes of death have clearly shifted from acute, short-term diseases to chronic diseases. Our lives are not so much threatened by the diseases of childhood as they are by the diseases of middle and old age.

"...The benefits of preventative health care may not be seen immediately, therefore, I feel that the government should look at the long term benefits of preventative health care when allocating medicare funding."
Valerie J. Kamitomo

"Preventive health measures must also be cost justified and projections of dollars saved should be prepared to determine the kinds of programs that should be undertaken. This information must be made known to Albertans for it is they who will determine the success of the programs by their commitment to the programs. Albertans must also be made aware that the programs will only be successful if they commit to these programs and are accountable in some way for the success. For Albertans to be committed to the programs, I feel they must have ownership of the programs and have a part in setting the programs up."
Ms. Laurel Temple

The helpfulness of health promotion and illness/injury prevention programs has been challenged. It is not debatable whether such programs are helpful from the perspective of overall quality of life — or from the perspective of overall survival. What is debatable, and some suggest even questionable, is whether — in the final analysis — such programs will produce cost savings. This is true, not just for promotion and prevention, but also for treatment practices which prolong life. Life, after all, is a terminal event — we all die. Money spent on promoting health and preventing disease and injury — while increasing survival but allowing a longer period of disability prior to death — may simply result in cost deferral, rather than cost savings.

Is health promotion and illness/injury prevention worth doing? Yes.

Who should do it? All of us.

How do we do it? With great difficulty!

Why so? Because it is much harder to motivate people to be concerned about health when they are well — and most of us believe we are well — or to inspire people to practice prevention when we think nothing will happen to us — and most of us think nothing bad can happen to us, particularly if we are young and in our prime and old age seems so far away.

HEALTH PROMOTION AND ILLNESS/INJURY PREVENTION

There are two major themes to this section. The first deals with the role of individual Albertans in maintaining or increasing our own health. The idea is to make us responsible for our well-being — by providing healthy public policy, making healthy choices easier choices, strengthening community action, and developing personal skills. The second major theme deals with reducing preventable disease and injury.

Health promotion as a strategy assumes that an individual is best able to deal with his or her own health, thereby decreasing the time that the individual is in the formal health care system. This emphasis on health promotion was a strong message from the people of Alberta through the "Townhall" meetings, submissions both public and private, letters, and telephone calls, and has become one of the three parts of the mission statement from the Commission.

"We have to consider the personal responsibility of the health care consumer to take care of themselves."
E. Smith

"That there be better education of the public in general about their own health. This can be achieved through health promotion programs."
Jean-Claude Martin

"The Province of Alberta has the potential to become a world leader in the area of injury control at this time. Several excellent provincial programs already exist in the area of injury prevention. What is lacking at this time though is a clearly defined focus of what future directions should encompass. It is estimated that injuries are costing the Alberta economy well over $2 billion annually."
Injury Awareness and Prevention Centre,
University of Alberta

"...I have osteoporosis...the osteo could have been prevented by information we have now...it would seem that education in childhood and early youth could prevent many diseases."
Mrs. Pat Brennan

"There should be emphasis on prevention of disease particularly as it relates to environmental causes, and diseases in which mortality and morbidity can be reduced through early intervention (e.g. heart disease, diabetes).
Dr. Robert G. McArthur

"The unique health care needs and concerns of each community must be addressed at the local level."
R. Bell; L. Doan

"It is recommended that individuals and especially the heads of families need to learn, more than ever before, how to take care of their health and to make it last for a lifetime; education in this direction is important."
H. Reiswig

Our recommendations refer to the *evolution* of a newer concept for health — one that recognizes links between human health, and our social as well as physical environments.

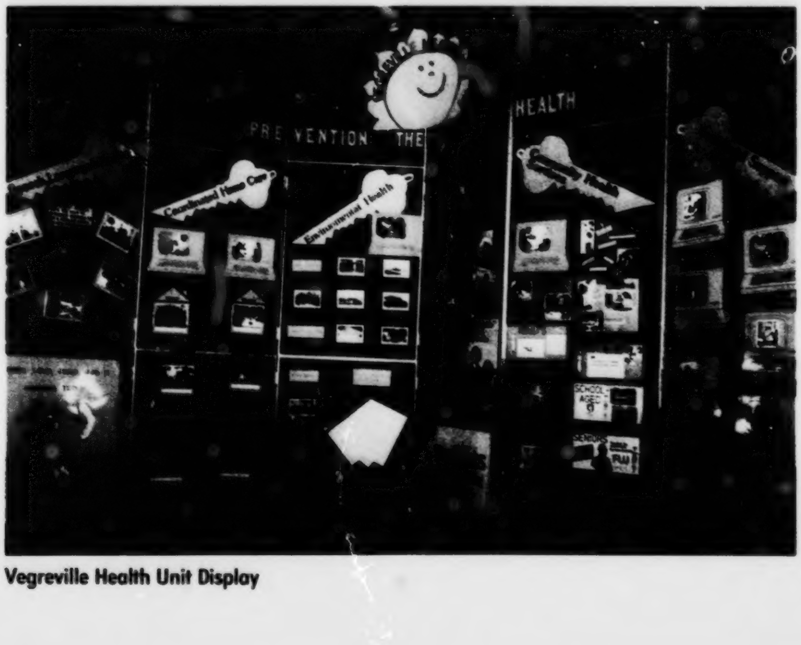
To meet the health and health care needs of all Albertans effectively, there must be a balance among:

— promoting individual responsibility for achieving and maintaining health;
— reducing preventable diseases and injuries;
— having an efficient, effective and economic health care system; and
— helping with ongoing health care needs through extended care, and rehabilitation, both facility and community-based.

Health promotion as one strategy among the others — to achieve health for Albertans — has some major difficulties. These include its recent recognition as important, its narrow base of support, finite resources, shortage of applicable programs, and a perceived lack of public and media appeal. Regardless of what health promotion proponents say, individuals generally are more interested in care through treatment of disease and injury by others than in the hard work necessary to achieve the elusive goal of complete well-being.

The second major theme deals with reducing preventable disease and injury. Prevention of disease occurs at three levels:

— *primary prevention* through protection measures including immunization and environmental sanitation/hygiene;
— *secondary prevention* through the early detection and prompt treatment of diseases, aimed at ensuring or slowing disease progression, preventing complications, and limiting disability; and
— *tertiary prevention* through the limitation of disability, and rehabilitation where disease has already occurred or left residual damage.



Vegreville Health Unit Display

But there continues to be confusion as to where health promotion stops and disease prevention starts.

Disease prevention is well-described by the Health Unit Association of Alberta when they represented public health as:

> *Not truly a discipline in itself, public health is rather an amalgamation of many disciplines which share a concern for the health of all members of society. It implies the assumption of responsibility by the community and incorporates the principle of "the greatest good for the greatest number". It seeks out individuals at risk; it provides those services that are best planned on a community-wide basis; and, it addresses the problems of inequity in society which bear on individual health. It differs from preventive medicine mainly in the way the responsibility is shouldered. The latter term being usually applied to interaction between provider and client. In these circumstances, the individual must be motivated to seek attention, whereas in public health, the system reaches out to him.*

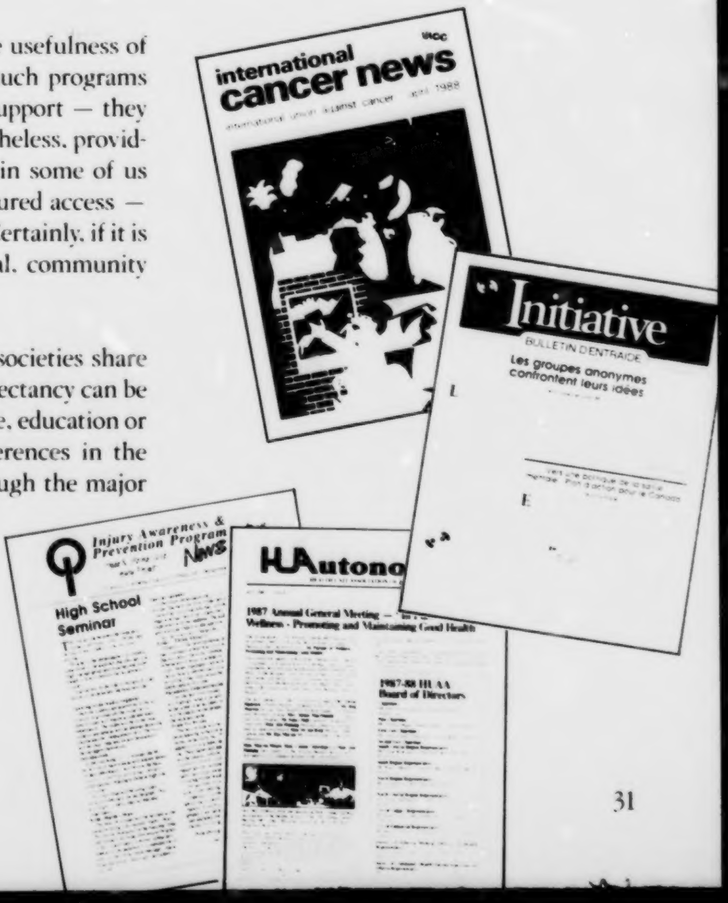
There is a difference between "reaching out" and "waiting for" — the former means equity (assured access), the latter equality (equal access). The concept of the system "reaching out" is critical to the whole notion of prevention. Just how much can society do for its collection of individuals? If there were infinite resources, would there be infinite health? Of course not. But can we, by reaching out, achieve major changes in attitude which will in turn result in major changes in health?

Projects exist throughout the province that attest to the usefulness of reaching out. They provide equity within the system. But such programs must and should be directed at some of us who need special support — they are not necessary, nor are they appropriate for all of us. Nevertheless, providing the "greatest good for the greatest number" may result in some of us getting lost in the shuffle. Equal access is not necessarily assured access — and assured access is the goal, even if it may be unachievable. Certainly, if it is to be achieved, it is more likely to be achieved through local, community approaches than through centralized, provincial approaches.

There is increasing evidence that members of modern societies share very differently in the improvements to health status. Life expectancy can be graded by social class or status — whether measured by income, education or occupational status. These seem to be independent of differences in the availability of, or access to, health care, and persist even though the major causes of death have been changing.

The uniqueness of the Boyle-McCauley Health Centre is something that has often been underscored: It is community run, functions on a walk-in basis, accepts patients without Alberta Health Care coverage, has doctors who work for a salary instead of on a fee-for-services basis, uses nurse practitioners to do community outreach, and services an inner-city clientele ranging from young immigrant families to "skid-row" folk to a high percentage of elderly people.

Boyle-McCauley
Health Centre
Newsletter


UICC
international cancer news
international union against cancer april 1988
Initiative
BULLETIN D'ENTRAIDE
Les groupes anonymes confrontent leurs idées
Injury Awareness & Prevention Program News
High School Seminar
HUAutono
1987 Annual General Meeting
Wellness - Promoting and Maintaining Good Health
1987-88 HUAA Board of Directors

One of the concerns expressed at the Pincher Creek Town Hall Meeting was the interdependency of health and the environment.

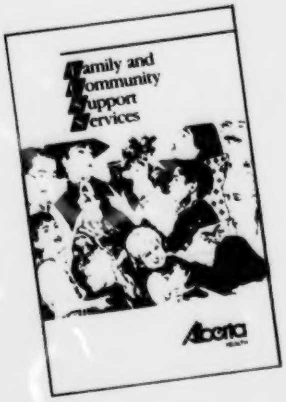
From the Athabasca Public Town Hall Meeting came this statement — that citizens must have the right to make and control choices regarding their own health.

That is not to denigrate the importance of what we traditionally think of as health care. In the course of this century, advances in medical understanding and technique have significantly expanded the range of circumstances in which medical interventions can be decisive for the health or even survival of particular individuals.

But it is clear from population-based evidence that the determinants of health go far beyond health care. In the past decade, there has been rapidly growing interest in new evidence showing a relationship between the structure of the social support system, the individual sense of control over the environment, and resistance to disease or injury.

Particular established areas of research include the relationship between health and poverty, and health and unemployment. Recent evidence suggests, however, that the influences of poverty or unemployment are more subtle than the obvious effects of deprivation — inadequate diet or shelter, for example. Mortality and morbidity extend across the range of classes, or income or education levels. They are not simply a result of some person falling below an absolutely minimum standard of resources necessary to maintain health.

Another fascinating area of research looks at whether those who drink alcohol and smoke pay the cost of related health care treatments through excise taxes on alcoholic beverages and tobacco products. Canadian data are not available, but a Rand Corporation study in the United States estimates that heavy drinkers — those who drink more than two alcoholic beverages per day — cost society 48 cents for every drink of liquor, glass of wine, or 12-ounce glass of beer consumed. This is more than double the 22 cents-average tax per ounce levied by federal and state authorities. Smokers cost 38 cents for every pack of cigarettes they smoke in their lifetimes. But they come close to paying their health care way, since taxes average 37 cents per pack.



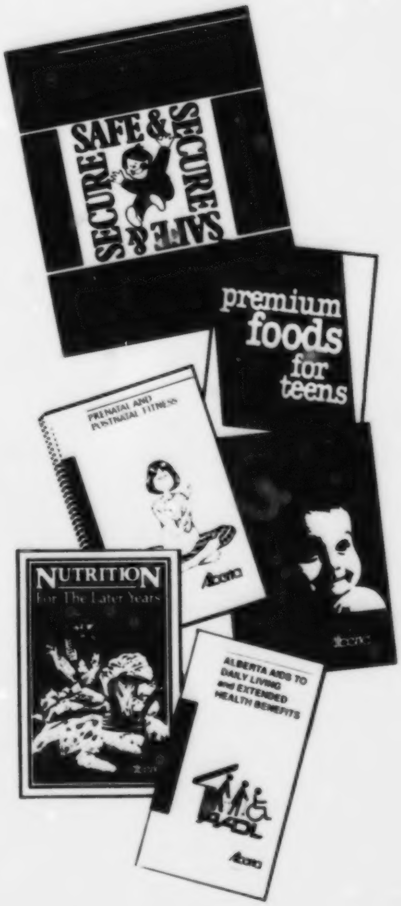
A glimpse at promotion and prevention in Alberta

Family and Community Support Services (FCSS) facilitates promotion and prevention services at a local level. They operate in more than 250 municipalities, counties and reserves throughout the province — working with communities to provide information and referral services, family life education, counselling, parent/child development, youth programs, home visits, meals on wheels, and homemaker services. Specific needs are identified and planned locally with FCSS workers, and funded through Alberta Health and municipalities on an 80/20 cost-shared basis. Approximately 1.5 million recorded volunteer hours are contributed annually to FCSS activities, ensuring that these services are available to approximately 80 per cent of all residents of Alberta. The grassroots community action and facilitation approach of the FCSS model should be extended to the Health Authorities.

A wide variety of volunteer organizations, including the Canadian Mental Health Association, the Canadian Cancer Society and Alberta Heart and Stroke Foundation, to name but a few, offer basic public education programs and awareness campaigns. Indeed, it is probably correct to say that most information concerning health promotion and illness/injury prevention comes from disease-specific volunteer organizations. Numerous other initiatives concerning promotion of health in Alberta are in place, including the following:

The Healthy City Project Association which is operative in Calgary, Edmonton and Red Deer, and has as its goal the enhancement of health in cities, their environment and their people by mobilizing resources of local governments and communities. Critical to this effort is the involvement of lay people with health care professionals, working together for change.

Food and nutrition projects sponsored by such organizations as the Edmonton Board of Health "Heart and Soul" project and the Leduc-Strathcona Health Unit's "Food for Life" program.


SAFE & SECURE
SECURE & SAFE
premium foods for teens
PRENATAL AND POSTNATAL FITNESS
Alberta
NUTRITION For The Later Years
ALBERTA AIDS TO DAILY LIVING and EXTENDED HEALTH BENEFITS
AADL
Alberta

The Recreation, Parks and Wildlife Foundation leadership and commitment, in cooperation with Alberta Recreation and Parks, Alberta Health and Alberta Education, to enhance awareness of healthier lifestyles among Albertans through its "Come Alive!" program. This also is particularly visible through the development of an Alberta Centre for Well-being "to further the advancement of concepts and benefits of well-being to Albertans". The project is a joint venture of the Foundation with the faculties of physical education at the Universities of Alberta, Calgary and Lethbridge.

Alberta Agriculture's programs which focus on rural Alberta, with specific activities directed at public education.

The Alberta Alcohol and Drug Abuse Commission (AADAC) which provides major prevention programs for a wide variety of audiences, particularly including their internationally recognized program for teens, in place since 1981.

PRIDE (Parents' Resource Institute for Drug Education) in Calgary and Rocky Mountain House which works on the basis of parents helping parents through crises arising from drug and chemical abuse among their children.

Alberta Health initiatives to improve the overall health of Albertans, including the recruitment of a permanent director of mental health promotion within the department.

The Alberta Dental Association is recognized as a Canadian leader in dental health care promotion. Oral health promotion efforts in Alberta have been rewarded by a decreasing incidence of dental disease among young Albertans. During the next quarter century, the Alberta Dental Association will serve Albertans by adopting an enhanced dental health promotion leadership role in addition to the traditional provision of high quality dental health care.

A Framework for Future Dental Health Promotion for Albertans — ADA July 1988

Major programs are in place with respect to prevention at primary, secondary and tertiary levels in Alberta. Some of these involve the three orders of government — federal, provincial and municipal. Others include Public Health Unit initiatives, the acquired immune deficiency syndrome (AIDS) strategies which currently run into millions of dollars, and municipal Boards of Health programs. Numerous activities of professional organizations, such as the Alberta Dental Association and its major program directed at reducing dental decay, have experienced measurable successes. A growing number of volunteer organizations provide major public awareness programs.

The general question of legislating safety continues to be controversial. An example is seat belt legislation. The use of seat belts clearly saves lives. Legislation clearly increases the use of seat belts — when the seat belt law was in effect in 1988 in Alberta an estimated 87 per cent of motorists were using seat belts, but that figure dropped to 50 per cent when the legislation was quashed by the courts in 1989. It will be interesting to see how the number of deaths and injuries related to use and non-use of seat belts are affected now that the legislation has been reinstated by a higher court. Because of this unusual legislative circumstance, a useful natural experiment is possible.

The Emergency Department nurses at the Bow Valley site of the Calgary General Hospital are studying the type and extent of injury in patients admitted to the unit according to whether the patient was or was not wearing a seat belt. Because they have information for a time interval during which the use of seat belts was not regulated by law, and will have similar information after the reinstatement of seat belt regulation, a particularly useful comment on the importance of wearing seat belts should be forthcoming.

Most people in Canada, and now in Alberta, agree with seat belt legislation. But this is not necessarily true for legislation which generally affects our rights to act in certain ways. There is a growing resistance to the ever expanding set of health regulations. The question of when it is appropriate to impose on someone a legal requirement to do something is open constantly, and evolving. And it must be so. The question of if and when it is appropriate to substitute society's definition of personal well-being for that of the individual, and so introduce another health regulation, is fundamental to our view of democracy and our understanding of the difference and distinction between collective and individual good and need. Further, regardless of the importance of collective and individual good and need, as Daniel Callahan of the Hastings Centre said, "A life dominated by the avoidance of risk, the prevention of injury and the vigilant eye of the state could soon lose much of it charm."

And elsewhere?

Many successful health promotion programs are in operation elsewhere, including the Heartbeat Wales Program; the Health Education Program targeted at women from age 35 in Western Sydney, Australia; and the Workplace Health Promotion Program which is a cooperative project of Health and Welfare Canada and the Addiction Research Foundation of Ontario.

Participaction Canada is a nation-wide initiative designed to "make Canadian people more conscious of the value and benefits that come from a physically active lifestyle and to inspire them through information and promotion to assume greater responsibility for their health and fitness".

"It is recommended that healthy public policy needs to become central to every decision made at every level of government."
Wetoka Health Unit Board

What should we be doing?

We believe Alberta should articulate a coordinated healthy public policy — a targeted approach with specific goals and measured achievements, supported by government policies that would ensure that resources are provided to bring about comprehensive, complementary, and supportive programs of healthy living. Albertans should be given the opportunity to pursue healthy lifestyles under the best possible social and environmental conditions.

Such action would result in an increased length of life and quality of life for Albertans — ideally not just adding more years to life, but adding more life to years. It also should result in specific outcomes such as the reduction in infant mortality, and the reduction in the mortality rate due to accidents, injuries and preventable diseases.

To do this, we must be willing to put words into action — to provide structure and resources to support bold initiatives. It allows innovation and commitment at the local level to flourish. With encouragement, the success stories from one area could become commonplace achievements elsewhere. Ambitious policies and programs should not be started without adequate funding — and this funding should be the result of negotiation between the funders and the providers.

"That there be redirection of health care funds into more communities, primary level services especially those that stress the health promotion and disease prevention."
Boyle-McCauley Health Centre

"There must be a change in attitudes, a change in perceptions, and a change (in) the way Albertans view and respond to health care. Alberta must adopt a new focus and provide the necessary funding to create a situation where we will not do without but need less."
Alberta Society of the Friends of Medicare

"That there be public education programs, beginning in schools to help people understand the link between poor health and nutrition, stressful lifestyles, alcohol and drug abuse, careless driving, lack of exercise, and teenage pregnancy."
Grant MacEwan Community College, Social Policy Class

"The strategies needed to improve health...are a mixture of legislation, community organization, public and professional education."
Calgary Board of Health

1.0 **THEREFORE, WE RECOMMEND that the Government of Alberta, using a phased-in approach starting in 1990, provide additional funds from within the Alberta Health budget for health promotion and illness/injury prevention, so that by April 1, 1995, the department is spending at least one per cent more of its overall operating budget on these areas;**

1.1 that specific areas for improvement be identified annually as priorities and targeted for community-based promotion, protection and prevention programs; and

1.2 that goals be set for such programs, and that their effectiveness be measured in order to retain funding.

Directions for Implementation

The directions suggested for implementing the recommendation would require that goals for reduction of preventable health problems be targeted, and made quite distinct from the goals of health promotion in order to match the resources in the area of public health to meeting these separate sets of goals. Identifying preventive measures separately from promotional measures would clarify areas of activities and avoid duplication, and avert sacrificing resources from preventive services to develop promotional services.

The health goals that are set for Alberta are numerous, but could include several areas:

— significant reductions in teenage pregnancy;
— healthy heart programs to promote cardiovascular fitness and reduce cardiovascular disease;
— reductions in deaths, particularly among young children, due to motor vehicle accidents and the lack of use of seat belts and helmets;
— reductions in deaths, including suicides, particularly among youth, caused while under the influence of drugs and/or alcohol;
— reduction in the consumption of alcohol among all Alberta age groups;
— increases in school-based counselling programs to assist students in dealing with stressful life situations;
— marked reductions in the incidence of breast cancer and lung cancer;
— significant reductions in inappropriate drug prescriptions for the older population;
— development of neighbourhood health experts;
— reductions in racism, sexism and other alienating behaviours that influence health;
— reductions in sexually-transmitted diseases, including the incidence of AIDS; and
— overall improvement in the health status of Albertans.

In addition to selecting specific areas, actual targets of reduction should be set. A variety of examples are available. One of the best examples is that presented in "An Agenda for Action: Report of the Advisory Committee on the Utilization of Medical Services" (Alberta, 1989). The Committee suggests attaining the following health status targets by the year 2000:

— decrease perinatal death rate by six deaths per 1,000 live births;
— increase average birth weight to 4 000 grams;
— decrease suicide rate to 10 per 100,000 population;
— decrease deaths due to motor vehicle accidents to 10 per 100,000 population; and
— reduce in-patient hospitalization rate by 10 per cent.

Other examples can be found in the Quebec Health Goals which include the reduction of cardiovascular mortality or illness by 20 per cent, breast cancer by 20 per cent, and the incidence of lung cancer by the year 2000.

Or the approach presented by the Calgary Board of Health in its submission to the Commission — detailing goals related to injury control, cardiovascular disease, reproductive health, tobacco consumption, and independence in old age — might be used.

A further direction for implementation deals with the coordination of strategies and programs. There is a need to mount long range programs that coordinate a variety of strategies with enough impact to bring about new trends in health behaviours. There is an opportunity to mobilize extensive local programs involving Health Authorities, health units, FCSS, family physicians, and others by selling them on participation in coordinated programs — developed to address particular targets within each regional Health Authority. At the local organizational level, all groups with a role in health promotion should be encouraged to work together at the planning, development and delivery stages.

The Family Life and Drug Abuse Foundation is currently seeking public submissions on various approaches to fulfil its four-point mandate — education, community involvement, treatment, and research and evaluation. The Commission applauds the government's efforts to ensure that programs are relevant to the needs of Albertans, and encourages individuals, families and organizations to take advantage of this opportunity for direct involvement by participating with ideas, comments and proposals.

A final direction for implementation relates to research in health promotion and illness/injury prevention. Research efforts will be needed to support health promotion through health behaviour research, and program design research as examples.

"We have raised a generation that does not understand what responsibility means, and its philosophy is 'the Government should do it.'

It is recommended that the government should take less responsibility for future health care and each individual should take more responsibility."
R.M. Dykes

"Everyone should take control of his own health. Alberta must encourage a health care system which advocates individual responsibility and reward those individuals who do."
Alberta Hospital Association

"It is recommended that there be an emphasis on consumer responsibility, clinics for 'well seniors'."
Alberta East Central
Health Unit

Identifying specific areas and establishing realistic targets and timelines will be a formidable task. It will require a high degree of cooperation and coordination among a variety of government departments, agencies and volunteer organizations. Goals and objectives may vary from one Health Authority to the next. Nonetheless, it is imperative that such goals be set, and that the effectiveness of the programs be measured on a regular basis, and that the results be reported. Continued funding will be contingent on success. As part of the process, information on role-model programs will have to be shared and communicated among program coordinators and to the public.

Overall, it may not be enough to just say "do this, do that". A few "thanks" might be in order for people and organizations that develop and implement innovative proposals for health promotion and illness/injury prevention. A competition to provide awards for innovations and ideas should be established by either the provincial government, the Health Authorities, or the Advocate for a Healthy Alberta. The competition, emphasizing individual responsibility for health, could be patterned after the U.S. Department of Health and Human Services Award for Innovations in Health which has involved and honoured students for their ideas for the past seven years.

HEALTH INFORMATION, EDUCATION AND AWARENESS

To enhance the possibility of introducing helpful initiatives in the general area of health promotion and illness/injury prevention, it is necessary that Albertans be supported in our desire to develop health seeking behaviour. This means information must be available province-wide in understandable, useable, and meaningful forms, and that appropriate information technology for information transmission be identified and used.

At this time — despite international acclaim for some innovative and highly successful programs — most activities directed at informing Albertans about healthy living are developed in isolation by separate agencies and volunteer groups. Without a more coordinated effort, widespread benefits will remain limited.

Several important initiatives are in place. For instance, the Alberta Education junior high school health curriculum was piloted in 1986, and the Career and Life Management (C.A.L.M.) courses for grade 11 students was approved in 1989 and became a mandatory course for graduation from high school. Local health units provide health education in schools, and a variety of community outreach services have been developed by separate agencies and volunteer groups. A community outreach suicide prevention program — exceptionally well-integrated into communities with numerous agencies involved — was developed at the University of Calgary in response to that problem. Indeed, based on its success, the Alberta-developed suicide prevention program has been "exported" to the United States.

Programs relating to health promotion and illness/injury prevention are in place or proposed for our universities in Alberta. However, a major problem relates to our teachers not being taught how to teach the basics of health-related topics, nor is the promotion of psychological health being focused on in current course work.

During the past decade, Alberta industry has recorded almost a half million injuries which resulted in lost time from work. The pain and suffering has been immense, while the cost is estimated in excess of $2.5 billion. Avoiding such injuries obviously has many advantages.

Various programs have been launched by the Workers' Compensation Board and Occupational Health and Safety as well as various industry safety associations in an attempt to create an awareness among workers of safety procedures. Incentives are being provided to selected industries able to reduce the incidence of lost time due to accidents. Another program of importance, recently introduced by the Alberta Safety Association, was developed by the Task Force on Accident Prevention of the Alberta Chamber of Resources.

As well, the Northern Alberta Institute of Technology (NAIT) has launched a two-year pilot project for "Wellness Coordination" which involves planning, developing, promoting and coordinating a diverse range of "wellness" activities for its 1,500 employees.

Recently, the Injury Awareness and Prevention Centre of the University of Alberta launched "Heroes", a campaign centred around Albertans who have experienced disabling injuries — a unique province-wide prevention program aimed at encouraging high school students to make safe choices.

Programs, specifically designed for older people, to bolster their image and self-esteem, as well as to improve their physical health, have begun to emerge in the past few years. The most notable Alberta example is "Fully Alive", a program developed and implemented as a three-year pilot project in 1985. It was sponsored by the Alberta Council on Aging, funded by the Health Promotion Directorate of Health and Welfare Canada, and supported by the University of Calgary.

Various other initiatives are in place, province-wide and nationally as well as outside Canada.

"Teachers lack special training or expertise in health care issues.

Encourage teacher education programs to produce teachers who are competent instructors in the field."
Faculty of Education,
University of Alberta

A PROGRAM FOR TEENAGERS

"The APHA recommends that the Government of Alberta encourage the universities to examine their role in relation to education, training, and research in the field of health promotion and healthy public policy."
The Alberta Public Health Association

Targeting in the workplace is of considerable importance as well. For example, the National Institute of Occupational Safety and Health of the United States developed a list of 10 leading work-related diseases and injuries, and developed preventive strategies at national conferences in 1985 and 1986. The targets, selected on the basis of incidence, severity, and amenability to prevention, are:

— occupational lung disease;
— musculoskeletal injuries;
— occupational cancers;
— severe occupational traumatic injuries;
— occupational cardiovascular diseases;
— disorders of reproduction;
— noise-induced loss of hearing;
— dermatologic conditions; and
— psychologic disorders.

It is estimated that 56 per cent of the causes of chronic disease is related to how we live our lives on a day-to-day basis. Supporting and promoting health at work — including unpaid work — will have a powerful impact on Albertans. A similar approach needs to occur among the general public and particularly in our schools and health facilities. Increased public knowledge about living healthy, and grassroots support for and involvement in public policy affecting health is contingent on the commitment and encouragement of all orders of government.

Most of us are familiar with the promotional side of "Participaction", but more of us should be taking advantage of their other services. Participaction provides fitness promotion services to government agencies and private corporations to assist them in planning, designing and implementing fitness and nutrition campaigns tailored to appeal to the needs of employees. As well, they have established a communications network for the exchange of information among fitness, nutrition and health experts and clients who are seeking to improve conditions within their workplaces.

A variety of approaches are being taken by companies to alleviate stress among their employees. "Mental health days" — also known as Golden Fridays — provide official paid time-off work as part of corporate policy at more than one-third of all companies in major Canadian cities. The idea has lessened the "phoning-in sick scam" since many employees feel they are entitled to their sick-days-per-month as time off. Other companies provide fitness and recreational facilities and have opened them to the families of employees. With more women entering the workforce, some companies have provided on-location day care centres. Such actions promote increases in productivity, and generate a greater sense of loyalty and belonging — not just on the part of the employee, but family members as well.

What should we be doing?

Achieving personal well-being must become more important to us as individuals. This aspiration must be supported and nurtured where we live, learn and work. Albertans in positions of influence — teachers, business people, legislators, members of the media, health care providers — must take the lead and become role models in their own level of knowledge, their health practices, and within their work environments. By setting healthy behaviour examples — and providing all of us with the same opportunity to achieve and maintain our health — Alberta can attain unprecedented standards for quality of life among all age groups.

2.0 **THEREFORE, WE RECOMMEND that the facilities and departments of the Government of Alberta, including publicly-funded institutions such as schools, hospitals and post-secondary institutions, become role models of healthy environments and practices;**

2.1 that employers be encouraged to provide health promotion and illness/injury prevention information and assistance, and physical fitness facilities or opportunities as standard benefits of employment; and

2.2 that Alberta Advanced Education provide course development funds to enable faculties of education to offer health as a major or minor field of study to educators attending Alberta's universities.

Directions for Implementation

The government must set the example by introducing public service employee programs within its departments and institutions which would set a healthy example and provide a model for industry to follow. Recognizing that good health is profitable and leads to increased productivity, the government should encourage industry — particularly small business — to maintain the momentum that has already begun in promoting health in the workplace as a fundamental short-term strategy. Many programs are already in place and could be extended.

The Future...we all want to lead productive, healthy, happy lives.

"That the province should provide the support necessary to develop community health education and research as a logical development within the Faculty of Medicine and related Health Sciences faculties."
Faculty of Medicine,
University of Alberta

Both private and public sector employers and employees' associations should provide mental and physical fitness reinforcements as standard benefits of employment — systematically identifying and reducing or removing barriers to fitness in the workplace. For instance, there must be more wide-spread understanding of interpersonal behaviours that increase stress, and measures put in place to manage such situations. Property developers should be encouraged to include fitness facilities in their buildings — and tenants should begin requesting such facilities as part of their leasehold agreements. Employers should adjust work schedules to accommodate the time required to exercise or work-out; contact Participaction Canada regarding access to proven programs for employees; and consider bonus plans or assistance for employees who participate in self-help programs to, for example, lose weight or stop smoking.

In addition, cafeterias and vending machines — particularly in schools and hospitals — should provide healthy diet choices. More restaurants should begin identifying caloric content and other health information about their meals.

Educators must be given the opportunity to become knowledgable in health and healthy behaviours so they can teach our children. As more parents enter the workforce, greater onus will be placed on the schools to impart information on how to make healthy choices. Children often prepare their own meals and should make sensible food choices which satisfy their nutritional and energy requirements.

Healthy Albertans able to participate actively in learning, work and leisure are our most crucial resource. As we move forward in our journey into the next century, the energy needed for living will flow from our mental and physical health. Such health stems from our ability to create and coordinate multiple approaches to reviewing and reducing barriers to individual and collective health. Through the achievement of these goals, we will ultimately achieve that "complete state of well-being" we seek.

CHAPTER TWO

PEOPLE: THE REAL FOCUS

THE CHANGING FOCUS

The concerns and views of tens of thousands of Albertans are reflected in the Principles developed by the Commission to guide our deliberations and assist us in formulating our recommendations. We believe in ***people*** being the focus of the health system; in free and voluntary ***choice,*** personal responsibility, and duty to others; in the inevitability and desirability of ***change***, and in our ability to manage change to accomplish our purposes; in health ***decisions*** which are most effective and least intrusive; and in making the ***opportunity*** available to all Albertans to maximize their own health.

"The philosophy of prevention is a relevant issue when discussing future health care. Education of consumers and medical staff in a wellness model rather than an illness model is a first step."
Family & Community Support Services — Lacombe & District

The messages the Commission received from Albertans centre around a willingness to accept greater responsibility, a desire for more autonomy, and the right to live and die with dignity. As individuals, we want to control our own health decisions but require knowledge and policy support to do so. People, when armed with resources and knowledge, can control and be responsible for personal and family health and health care decisions. If appropriate linkages exist between various components of the system, all of us can more easily and wisely use the system. If there is coordination, then the system will serve all of us more efficiently and effectively. Sometimes decisions about health care are very difficult and we need to support one another in making those decisions.

"Health professionals must be willing to accept new roles if they are to keep up with the times. This may mean refocusing efforts in training health professionals to be educators as well as experts in their field."
L. Temple

These aspirations have developed within a rapidly changing health care environment — an environment in which individuals are much more knowledgeable and demanding, albeit sometimes skeptical or confused. At a time when we face an incredible knowledge explosion for both consumers and providers, we are now expected to face the reality of constrained resources. We now recognize we cannot spend our way to the future — the system cannot grow forever. We must make responsible and relevant choices. Within this environment, the health care system is attempting to adapt; and this adaptation can be especially difficult for certain groups — both providers of services and recipients of services.

The current health care system was designed to take care of us when we are ill, when we are hurt, and when we are in need of help. Over time, our expectations of what and how much that system can and should do for us have changed. In the past, "the health system" generally meant doctors and nurses being there for us in hospitals and clinics when we were sick. During the past few decades, other aspects of health — education and awareness, promotion and prevention, support and special care — struggled in the shadow of acute care for legitimate inclusion in the health arena.

"It is estimated that 60% of the causes of chronic illness is related to individual lifestyle or environment, factors that are to some extent controllable."
Alberta Blue Cross

Slowly, medical attention expanded from treating disease to increasingly complex activities that manage symptoms — we attempt to manage the pain of cardiovascular problems, the wasting of cancer, the immobility of arthritis, and the consequences of mental health problems. Conditions that cannot be cured or changed always will need supportive, on-going health care: relief of pain, adaptation of activities of daily living, and provision of emotional support.

To some extent, the focus has changed from being cared for to taking care of ourselves. This shift from a dependent to a more independent, responsible status allows the development of broader, more encompassing approaches to health. As well, there must be recognition and acceptance of the interdependent nature of services required for some of us who need special support. The process should be stream-lined to accommodate all of us more easily and effectively in health maintenance and illness prevention strategies.

In this context, attitudes and expectations must shift on three fronts. Consumers must relieve health care practitioners to do what each does best. Health care professionals must accept that they cannot be all things to all people. The health care system must adjust to the changing needs and demands of those of us who require services and those of us who provide them. Both consumers and providers need to develop viable partnerships — first with each other, and then with supportive and alternative care providers, self-help groups, and volunteers, thus increasing the relevance of the system.

"Consumers have the right to be informed about preventative health care including education on nutrition, birth control, drug use and appropriate exercise. Consumers should know their own diagnosis including prescribed surgery and medication, options, effects, side effects about the specific costs of procedures and other services."
Consumers Association of Canada (Alberta)

ALL OF US SOME OF THE TIME, AND SOME OF US ALL OF THE TIME

Need is an individual value. Sometimes we are sick. We are ill. We need help. We are beyond helping ourselves. The point at which we acknowledge that we cannot make ourselves well is enormously variable. Some of us seek help for what appear to be minor ailments. Others of us know when home remedies have run their course and professional advice is needed. A few of us wait until serious, even irreparable, damage has occurred.

"It is recommended that there is a need to develop specific approaches and services to foster health among specific target groups."
Suicide Prevention Provincial Advisory Committee

And when we seek help we turn to doctors…and doctors may lead us to hospitals. Hospitals can and should be places of support and caring — most of us who enter are in need of curative help and comfort. We may be frightened and confused — sometimes we don't understand what is happening to us. If we didn't have to be there, we wouldn't be.

Health care is a complex system of systems capable of handling all of us as long as our problems fall into slots that were created in reaction to real and perceived needs. Certainly most of us are resilient — once put back on the track to health within the system, we recover in the short-term and resume our normal routines. But some of us can't and don't recover, or do so more slowly than others. We need help not only within the compartments of the system, but we need support to move between the compartments to access different parts of the overall structure. For some of us the maze to accessing long-term care and assistance becomes almost as trying as our reason for requiring support.

"The public believes that the number of hospital beds is directly related to the quality of care given; this perception is untrue and must be changed."
The Edmonton Social Planning Council

"It is recommended that, because it is difficult to match the supply of beds with demand, some of the major rural hospitals should be used as an overflow for the regional and tertiary care facilities."
H.L. Morrison

Hospital-based health care services make up the largest portion of Alberta's health and health care expenditures. We have 125 general hospitals including two federal hospitals to serve acute care needs, some mental illness, and other specialty services such as cancer treatment and rehabilitation. In 1987-88, more than 32,000 health care providers treated 391,125 patients and delivered 41,997 babies in our hospitals. During the year, 2.48 million persons were covered by the Alberta Health Care Insurance Plan which processed more than 28 million claims on our behalf. We use the system to its fullest and it serves us reasonably well.

Certainly, from the standpoint of bricks and mortar and medical care and treatment, Alberta's facilities and services are among the best. However, it became clear to the Commission that the challenge is going to be in appropriately, efficiently and responsibly using what we have in place...and balancing the provision of services in an atmosphere of independence and interdependence. There must be a shift in the relationships between patients and providers, and among providers, and among hospitals and other health care facilities.

There is a tendency within the health care system to create and enhance our feelings of dependency. Basically, as patients, we give up control. Child-like, we accept being told what to do and when to do it, but seldom why we must. While this type of provider/patient relationship is traditional, it may be viewed by many as unsatisfactory to both.

"It is recommended that there be a change of resource allocation from hospital to outpatient care funding."
B. Vandermeer

Granted, there are circumstances when we need all the help we can get, but surely the level of care should appropriately suit the ailment. In emergency situations like heart attacks or in cases of severe illness, we want to be taken care of in a complete sense. A different approach is needed in caring for a woman who is having a baby and needs assistance, but is not sick.

The blend and balance

The Commission sees evidence of some changes of attitude, and anticipates the evolution of hospitals toward becoming intensive care units where patients receive major and complex treatment from highly skilled technicians. Hospitals will become centres of care for those of us who are drastically and urgently sick. Procedures that do not require such a high level of concentrated care will be dealt with increasingly on an out-patient basis or outside the actual hospital setting in clinics.

Such an evolution will require a particular blend and balance: while we increase our ability to treat, we must not lose our ability to care. We cannot end up "caring" only when "curing" isn't working. Good providers recognize that patients need psychological support...that "high-touch" is vital to the success of "high-tech"...that alternatives must be made to accommodate the needs and wishes of patients. Unfortunately, current funding practices are not particularly conducive to enhancing this balance.

Almost all births, apart from emergency situations, occur within a hospital setting. In Alberta most women want to deliver their babies in a hospital. Most doctors want to deliver babies in a hospital; and this is the policy of the College of Physicians and Surgeons of Alberta. Some Albertans told the Commission that they want more choices with respect to where they have their babies delivered. Indeed, this is the reason some hospitals are using birthing rooms more commonly. As well as access to family practitioners and obstetricians, there is growing support for more involvement of licensed nurse midwives. Certain hospitals now offer mothers the option of returning home with their newborns within 12 hours of giving birth.

One concern that arose from the Red Deer Public Town Hall Meeting June 20, 1988, was technical growth versus loving and caring.

Around the world, 75% of the babies born today will be born into the hands of midwives. The World Health Organization (WHO) recognizes midwives as the international specialists in normal childbirth. Numerous studies have repeatedly demonstrated that midwives provide the safest standard of maternity care. Canada continues to be the only developed country in the WHO that fails to recognize midwifery.

The Alberta Midwifery Task Force Pamphlet

"The manner of dying is as important to patients and families as the manner of living."
P. Friese

"The compensation for physicians in the community delivery of palliative care needs to be addressed. Physicians are expected to provide services such as telephone contacts, writing orders, and attending case conferences for community patients for which they receive no compensation."
Alberta Palliative Care Network

"In the palliative care phase, the health care system almost totally disintegrates leaving patients with a sense of abandonment and alienation. The system has never developed a program for this group of patients. Further, patients receive care in a variety of facilities.

Advanced care patients should receive the support it takes to remain at home. Their problems of self-respect and dignity must be addressed."
Alberta Cancer Board

Hospitals, for the most part, have taken on the administration function related to death. Death certificates must be signed by physicians, who are most readily available in hospitals. The process of dying naturally at home, or in a nursing home, has been threatened in part by these administrative constraints. For several decades, death has taken place more in hospitals away from the family than at home. Families fear relatives dying at home for a wide variety of reasons. A small part of the difficulty is "bureaucracy of death" forms which must be completed. More flexibility in the administrative area would make it easier for people who want to spend their last days in their homes. If we are to have personal control and support family involvement in the dying process, we must find ways to share the predominant role of the hospital in the legal aspects of dying.

Alternatives to dying in the hospital currently face many barriers. Physicians and other providers are discouraged from making home visits because of the time it takes, and the lack of access to technology necessary for diagnosis and treatment. As a result, some persons in the late stages of disease must travel to emergency departments and suffer long waits in order to receive care. The Commission feels that cooperative efforts by various legal and medical societies could provide guidance and suggest changes which could result in lessening some of the concerns associated with dying at home.

Palliative care is a program of active, compassionate care, primarily directed at improving the quality of life of dying persons and their families. The concept has gained prominence since the early 1980s in Alberta, partially because of the hospital-based, city-wide initiatives made possible by a private foundation grant in Calgary, and partially because of the introduction of a palliative care unit at the Youville Centre in Edmonton. The establishment of an Alberta Cancer Board Foundation Professorship in palliative care and the joint program involving palliative care at the University of Alberta Hospital, the Cross Cancer Institute and the Youville Centre all tied into a home care program. As well, the Misericordia Hospital in Edmonton recently established a palliative care program.

The Commission applauds these approaches, and supports continued efforts to develop such programs, including the component of pastoral care in our hospital and community-based facilities. Many briefs praised the tenets of hospice and palliative care, mainly on compassionate grounds. However, serious problems remain. Hospital-sponsored units often have low priority because of fiscal restraint. The choice between a machine or a program to prolong life versus a program for dying patients is not an easy one for hospital boards. In addition, there is an ongoing problem related to the barriers between hospitals, hospice units, and in-home supports. The gates — from both directions — are difficult to open.

Emergency services in Alberta are considered among the more advanced in Canada. We are one of the few provinces with accredited ambulance attendants in many parts of the province who are able to provide emergency medical care on the scene. The availability of such services has been steadily increasing. The Commission strongly supports the early institution of a province-wide ambulance service with standards of training and equipment, as recommended in "New Dimensions in Emergency Health Services: An Alberta Solution", a 1988 report by the Policy Advisory Committee to the Minister of Alberta Hospitals and Medical Care. In response, the government has released the draft of the new Alberta Ambulance Service Act.

All admissions to hospitals must be through physicians, but because many Albertans do not have family physicians, the emergency department is increasingly used as an entry into hospital services. This places an additional burden on emergency unit staff who must often make decisions without knowing the kind of background information a family physician would be expected to provide about a patient requiring admission to hospital.

While we might genuinely believe we need to be admitted for treatment, in fact, the priority for admissions should be set according to the degree of urgency, normally determined by the admitting physician. We should understand that typically, three classifications are used:

— *emergency* cases require admission because of immediate threat to life or limb;

— *urgent* cases require admission as soon as possible, usually within 72 hours, or within one week at most; and

— *elective* admissions are scheduled in advance according to the policy of the hospital. For example, patients may be admitted in the order in which their reservations were received; while chronic care or rehabilitation hospitals may have an application and review procedure for admission.

Our emergency room services often are not used properly. For every 1,300 injury-related emergency department visits, 45 patients warranted admission to hospital, and one hospital death occurred. The rest were treated and sent home. Because many hospital emergency departments are open 24 hours a day, there is a tendency to overuse these services when care could be provided within a doctor's office or a walk-in clinic. The Report of the Advisory Committee on the Utilization of Medical Services - 1989, addresses many of the problems associated with the use and abuse of hospital emergency departments including research into patient use, and the role of emergency departments in hospitals.

"The issue of the length of transport time and response time must be decided upon. Rural settings currently determine an appropriate time through economic factors. This is wrong.

An arbitrary time frame should be determined. Such a frame should not be decided by economic factors, but through medical factors."

The Alberta Ambulance Operators Association

Hospital Discharge by Classification per 100,000 Population (1984/85)

		Canada	Alberta
Neoplasms	M	866	772
	F	1,023	974
		1,889	**1,746**
Mental disorders	M	577	680
	F	683	803
		1,260	**1,483**
Diseases of the nervous system and sense organs	M	647	774
	F	726	860
		1,373	**1,634**
Diseases of the circulatory system	M	1,862	1,675
	F	1,447	1,339
		3,309	**3,014**
Diseases of the respiratory system	M	1,616	2,121
	F	1,288	1,796
		2,904	**3,917**
Diseases of the digestive system	M	1,713	2,015
	F	1,616	2,047
		3,329	**4,062**
Diseases of the genitourinary systems	M	815	833
	F	1,564	2,082
		2,379	**2,915**
Complications of pregnancy, child-birth, puerperium	F	**4,093**	**5,641**
Diseases of the musculoskeletal connective tissue	M	731	1,018
	F	780	1,031
		1,511	**2,049**
Injury and poisoning	M	1,432	2,155
	F	1,009	1,474
		2,441	**3,629**
Total - All Diagnosis	M	**10,259**	**12,043**
	F	**14,229**	**18,047**

Source: Statistics Canada

For most of us, medical and surgical treatment is the central function of hospitals. The adjacent list of diagnoses at the time of discharge from hospital within the province, gives us some idea of the kinds of treatment that are most common among Albertans.

Hospital payment forms bias toward long-stay patients, but not for too long. After 60 days, the individual may be assessed as a long-term care patient and asked to pay the hospital nursing home rates. While this has posed less of a problem in most public general hospitals in the province, it creates real problems within the specialized active care hospitals and referral centres that require beds for short-term patients who are often very ill or badly injured.

We currently have both long waiting lists for various acute care services in some hospitals and bed closures in others. Most hospitals basically work on a five-day week except for general care. Much better use of hospital diagnostic and treatment facilities would be possible through an improvement in the efficiency or level of services provided. However, if higher numbers of patients and those requiring more complex care need to be treated, then additional funding from government or private sources may be necessary.

The need for special support

How do we reconcile the need for universal health care with the individual need for special support? The Commission acknowledges that all of us have the right to access health care services in this province, but cannot ignore the reality that barriers do exist for some of us. In this regard, individuals and groups made specific representations to the Commission — often appealing to our sensitivities in an emotional, yet factual, manner. We have chosen to use some examples that graphically illustrate the difficulties of coping with the complexity of the system. The circumstances described could, with slight modification, apply to any of us at some point in our lives. Who of us is immune to what fate may have in store for us or our family members?

Our young people: There has been a positive change in health service delivery for Alberta's children — increased ambulatory care services, greater parent participation in care, specialist treatment in the care of children, and reduced in-patient care generally.

The Alberta Children's Hospital in Calgary successfully provides specialized pediatric outreach services to local rural hospitals, increasing service accessibility to the more than 400,000 children in southern and south-central Alberta. A similar facility is being planned in Edmonton to provide specialized care and outreach programs for children in northern and north-central Alberta. While outreach services tend to be costly, the strain is counterbalanced by the increased expertise provided to smaller community hospitals, and the lessening of trauma for the children and their families at a time of crisis. For those children who have no choice but to leave home for treatment, hospitals are providing more of a family atmosphere, and private sector initiatives — like Ronald McDonald houses — can support families away from home.

Alberta has made great strides in changing the patterns of care for children with ongoing health needs and disabilities. In 1972, for example, 97 per cent of Calgary children with severe congenital disabilities, most of whom were under the age of three, were institutionalized. Just four years later only 12 per cent were cared for outside the home. While this is an appropriate direction to have taken, it was not without considerable burden and stress to many families. As a result of the provision of school programs for severely handicapped children and financial support through Handicapped Children's Services, such stresses are now being minimized.

Handicapped Children's Services is unique in Canada, providing funds directly to families with medically dependent, severely and profoundly handicapped children. Some families do not qualify for assistance, and must bear a substantial portion of the costs of maintaining children with disabilities in their homes because limited resources and supports were/are available. Local boards of health, school boards, hospitals, private services and volunteer agencies are trying to respond to families, but there is a need to develop broader and consistent health policies.

Overall, Alberta has almost no children with disabilities in social service institutions, and a declining number in nursing homes or auxiliary hospitals. It is necessary, however, to recognize that institutional support will always be needed by those who, for various reasons, cannot be cared for in their homes and communities.

Regrettably, certain rites of adulthood — drinking and driving — take their toll on our youth, especially young males, who enter the health care system through emergency departments. For many of these young people, the acute care phase is only a prelude to life-long rehabilitation directed at regaining the ability to think, feel and move.

Welcome

ALBERTA CHILDREN'S HOSPITAL
CHILD HEALTH CENTRE

Ronald McDonald House

"The Society for Children's Oncology Family Services of Northern Alberta."

"It is recommended that the concept of developing a network of consultant pediatricians visiting certain outlying communities should be encouraged."

Northern Alberta Children's Hospital

"Modify the AHCIP fee schedule so that interviews with unrelated persons concerned with disturbed children (social workers, teachers, educational psychologists, school counsellors, etc.) can be billed for. This is a large part of the practice of child psychiatry but at present is not paid for by AHCIP, a serious drawback to the practices of child and adolsecent psychiatry in Alberta."
Calgary Regional Psychiatric Services Planning Committee

PRIDE-Calgary works on the basis of PARENTS HELPING PARENTS. They offer support to parents in crisis precipitated by the drug and alcohol abuse of their adolescents.

"It is recommended that there is development of women's health care clinics that would provide a comprehensive approach to the health care needs of women from the age of puberty."
Planned Parenthood Alberta, Calgary Birth Control Association, Banff Planned Parenthood, Planned Parenthood Association of Edmonton

Since the 1960s, there has been an increase in awareness of child and adolescent mental-health problems; yet precious few major resources have been committed to addressing children's mental health. We must recognize that children, too, face the stresses of social problems — crime, divorce, suicide, alcoholism and other substance abuse, poverty, discrimination, sexual abuse, unwanted pregnancy, sexually transmitted diseases, child abuse, and family violence. More programs are needed to assist young people and their families to cope with these pressures and issues.

As well, there were serious concerns expressed by parents of teens who must travel to the United States for drug abuse treatment. While the Alberta Alcohol and Drug Abuse Commission (AADAC) is widely renowned for its prevention and counselling programs, its primary focus is not on treatment of young people suffering from substance addiction. Innovative programs — like PRIDE (Parents' Resource Institute for Drug Education) in Calgary and Rocky Mountain House, and Kids of the Canadian West which treats severely obsessive children with chemical and personality disorders — are being developed throughout the province. As well, the establishment of the Family Life and Drug Abuse Foundation is looked upon as a major break-through in the recognition that much more must be done. It would seem logical that some of the funds of the Foundation should be directed toward treating young Albertans within the province.

We face a number of challenges regarding the health of young Albertans. Some needs are not being addressed through the current way we provide care. Significantly more must be done in areas such as accident prevention, treatment for substance abuse, and home care.

Alberta's Women: Many of today's women have multi-faceted roles — as homemakers, parents, breadwinners, career people, care givers. Juggling responsibilities can lead to an erosion of physical, mental and emotional well-being. Women report more acute conditions and have a higher prevalence of chronic disease than men. Women and girls suffer seriously from a variety of mental health problems, and perhaps, in part, as a consequence receive 73 per cent of tranquillizer prescriptions. Because of childbearing, and maintaining the primary role in decision-making about child health care matters, women are greater users of medical services. The price of living longer than men is suffering from the diseases of old age and from loneliness.

A recent Alberta study highlights problems in women's access to health care. "Near poor" working women — many of whom are single parents — cannot afford health care premiums. Unaware that they cannot be refused medical services, or to avoid embarrassment and hassles, they sometimes fail to seek medical attention for themselves or their children. While disabled women can get institutional medical services, there are serious barriers to independent living, particularly for married women and single parents. They were distressed at having to leave home or give their children to others because there was no money to have someone come in to help. The stress of family breakdown or being institutionalized was worse than the disability. Separation from family and community also can affect health care decisions by rural women who must travel greater distances to access required services, particularly those of a specialized nature not provided in their local hospital.

"Diligent attention to the concept of 'equal pay for work of equal value' must be ongoing and improved upon in order to free women from the fetters of poverty that lead to increased consumption of Health Care for Disease and interrupted Promotion and Prevention of Wellness."
Federation of Medical Women — Alberta Chapter

In response to these, and other problems, women's groups and resources are springing up with a focus on health promotion and disease prevention. For example, having studied the functions of the Women's Health Centre at Calgary's Grace Hospital and other North American models, the YWCA and the Royal Alexandra Hospital in Edmonton are exploring the establishment of a Centre for Women: Health Information and Referral. The centre would fill gaps rather than duplicate services; and have health, rather than illness, and prevention, rather than treatment, as its goal.

The YWCA is a non-profit voluntary association. Sensitive to community needs, staff and volunteers strive for the improvement of individuals enabling them to reach their full potential in body, mind and spirit.
YWCA Mission Statement

The Commission would like to point out that Alberta's women are represented in this section of the report because, as a group, they made representations to us. We recognize that men suffer as well from lifestyle pressures which can lead to declining physical, mental and emotional well-being. Indeed, statistical data show them as higher health risks in various categories. Most men die sooner than women, and many, more violently as a result of accidents, aggressive acts or suicide.

As a society, we have become generally more aware of healthier lifestyle behaviours, and many of us — male and female — are taking positive actions to improve or maintain our health. However, women have been more inclined traditionally to share their difficulties and to organize into "helping-each-other" type groups. The tendency for male-oriented groups is to "help others", not each other. On a broader scale, most magazines directed at the male population concentrate on business, sports and topic-specific activities. Those designed to appeal to women, by and large, always contain regular sections and features on health and health aspects for women and their families.

"The Alberta Chapter of the College of Family Physicians of Canada recommends that the government explore and develop ways to support families who take on the responsibility of caring for their elderly relatives."
The College of Family Physicians of Canada (Alberta Chapter)

Elderly Albertans: Although the number of Albertans over the age of 65 is increasing, the majority are in good health and seldom use health services. Those who are able remain independent in their own homes or senior citizen complexes, or live with their families. While they have access to health care, the cost of medication can be burdensome for anyone, including many seniors, on a fixed income.

Alberta's senior citizens are major stakeholders in health care, using about half of all hospital care, 72 per cent of long-term care beds, 33 per cent of psychiatric beds, and 21 per cent of physician services. Overall, they consume 40 per cent of total health care expenditures. Escalating health care costs are not solely attributable to the processes of aging, but also to the residuals of preventable disease and the way we use high cost facilities. In fact, 12 per cent of acute care beds are occupied by elderly persons awaiting placement in other facilities. Access to homecare/home help can make the difference between senior citizens staying at home or going into an institution.

Older people with chronic health conditions often cannot be maintained in the community because they have trouble accessing short-term treatment or rehabilitation options that are open to those who are younger. With only 7.0 per cent of the long-term care budget being spent on community-based programs, the primary responsibility for support falls to family and natural supports who provide 80 per cent of the care required.

The senior citizens who addressed the Commission were clear in their message — they wanted a chance to stay healthy and out of health facilities for as long as possible. They wanted aging to be seen as an opportunity, not a problem. Age is, of course, purely relative! Sixty-five is the demographer's point after which an individual is classified as old. But age 65 as the beginning of old is mere convention established in the Nineteenth Century by the Iron Chancellor, Otto von Bismarck when he said, "Whoever has a pension for his old age is more content and easier to manage than one who has no such prospect." But what he didn't say was that in those days few workers actually lived long enough to collect.

It should be remembered that today's average 65-year-old still has another 18 years to live. However, some maintain independence for only another 10 years. The average independent 85-year-old will live another six years, but only half of these will be free of disability severe enough to threaten independent living. All of us should look forward to our greying, but some of us may view the future with anxiety. One of the seniors who spoke reminded us of the great French poet Claudel, who at age 80, said: "Eighty years old! No eyes left, no ears, no teeth, no legs, no wind! And when all is said and done, how astonishingly well one does without them." Fortunately, few of us, even at 80, need worry about such extremes, since services and technology can now maintain most of our vital senses.

"It is recommended that the role of the small hospital be expanded to include services such as adult day hospital programs for the elderly, provision of certain home care services under contract to local Health Units, health and wellness promotion programs targeted at various age groups and palliative care."
Bow Island Health Centre

Albertans of Native Ancestry: Close to 100,000 Albertans — 4.2 per cent of all of us — are of Indian ancestry. Alberta has the greatest number of Metis and non-status Indians, and the third highest Native population in Canada. Almost 55,000 are Status Indians under Treaty Nos. 6, 7 and 8, whose health needs are the responsibility of the federal departments of National Health and Welfare, and Indian and Northern Affairs.

"Many native persons face living conditions which few non-natives in North America have faced in decades. Many Indian reserves across Canada still lack access to safe drinking water and do not have adequate sewage treatment facilities."
National Council on Welfare

Increasingly, Alberta's Native people use local hospital systems and local doctors, although this may be at odds with their cultural view of health. Traditionally, the Medicine Man served as healer, spiritual leader and the Band's counsellor. He was responsible for physical, spiritual and mental needs as well as the community's social well-being. On the other hand, the Western approach to medicine seems to divide life and health into separate parts or fragments with specialists for each part. Those Bands who are active in coordinating health services are making an attempt to reintroduce the tenets of Native health into their health services on reserves.

"It is recommended that older natives need the development of services that relate to their culture."
Provincial Senior Citizens Advisory Council

Natives from rural communities and reserves are more likely to be transferred from acute care to extended care facilities because rehabilitation and ongoing support services are clustered in urban areas. All too often, when family and community ties are severed, they seem difficult to re-establish. Among Native peoples, long-term care facilities can represent banishment to another culture, and the sense among the elderly that their usefulness has been outlived. Loneliness and lack of family support and contact, worsened by a system that is foreign to the Native patient, can prolong the period of recovery. Natives at each end of the age spectrum — the young and the old — suffer the greatest disorientation and isolation.

Disabled Adult Population - Alberta
Age 15 & Over
Total Population of Alberta — 2,345,415
(1987)

Nature of Disability	% of Population
Mobility (moving)	7.07%
Agility (moving easily)	6.32%
Hearing	3.25%
Seeing	1.74%
Speaking	0.83%
Other	2.39%
Nature Unknown	0.78%

Source Health and Activity Limitation Study, 1988 — Health and Welfare Canada

Disabled Population
(1987)

	Canada	
Age	**At Home**	**In Institutions**
0-14	274,440	2,250
15-34	486,930	16,910
35-64	1,330,500	32,890
65-69	291,705	13,605
70-74	276,880	21,905
75+	458,330	158,575

	Alberta	
Age	**At Home**	**In Institutions**
0-14	30,090	*
15-34	51,385	1,200
35-64	107,710	2,180
65-69	20,085	1,130
70-74	20,565	1,690
75+	32,150	14,260

*numbers too small to accurately assess
Source Health and Activity Limitation Study, 1988 — Health and Welfare Canada

Persons with Disabilities: Approximately one in every eight Albertans has a condition that leads to significant reduction in the ability to carry out daily routines.

Almost all of our disabled population have spent time within the health care system during the diagnosis and treatment of their condition. For most of them there is no cure. Approximately one-third of all people leaving acute care hospitals with ongoing needs has problems associated with such diseases as cancer, chronic heart and lung diseases, and diabetes. Another third has problems associated with bones, joints, muscles and injuries. The remaining third has problems associated with head and spinal cord injuries, strokes or other neurological diseases.

While in hospital, disabled people are considered "sick" and medical treatment is believed to be the most appropriate response. Unfortunately, when they leave hospital, they most often have to continue using the label "sick" in order to get services. Many are placed in institutions because of an inability to provide community supports.

"Many people think of an institution as an active treatment hospital. I was not sick in the usual sense of the word — there were just a lot of things I couldn't do for myself. Otherwise, I would say I am healthier than a lot of people." (Shirley Garth, Long-term Care Consultation with Premier's Commission)

In the Commission's **Consultation on Rehabilitation and Long-term Care**, summarized in Volume III, consumers — people with disabilities of all kinds — told us they were ready to become partners in creating and managing ongoing health needs in a way that will allow them to get on with their lives. They insisted they were "differently 'abled', not disabled." This concept is well captured by the Premier's Council on the Status of Persons with Disabilities publication entitled, "Towards a New Vision of Abilities in Alberta - June 1989."

There is a vast difference between services for disabled individuals in rural areas compared to the services available in urban centres. Unless their families can assist or they can find alternative services such as attendant care in their communities, there is often no option but to move into institutions. This is a decision many disabled adults between 18 and 65 years of age who require ongoing support to maintain their health care needs must face, because generally they are not eligible for home-care services. The only alternative is to apply through social assistance. Improving linkages between government departments offering assistance programs could significantly reduce barriers to independence.

"It is recommended that funds be made available to develop, evaluate, and support outreach educational activities in rehabilitation."
Faculty of Rehabilitation
Medicine, University of Alberta

Many families are choosing to care for children and elderly adults with disabilities in their homes. If this trend is going to be encouraged and expanded within the community over the long term, additional assistance will be required. Regulations and policies governing how and for whom that assistance is provided will have to be reviewed and revised.

"It is recommended that if home care was available for persons with physical disabilities, and if the objective of the rehabilitation hospitals was to prepare people to live in the community, there would be an enormous cost saving to the provincial government."
The Alberta Rehabilitation
Council for the Disabled,
operating as The Easter Seal
Ability Council.

The role of the family care-giver is an emotionally and physically demanding one. Unlike professional care workers, family members do not receive standard benefits like pay and time off. To maintain a more stable and healthy environment, ensuring that family members do not neglect their own condition of well-being, more respite and personal care services are needed. Special services and day care options provide relief and allow family members to pursue economic and social activities, to restore their own physical and mental health, and to maintain positive attitudes toward the disabled relative.

In many instances, well-meaning individuals — professionals concerned "about" — and select groups — organizations established "for" — try to work out solutions to assist persons with disabilities without meaningful participation by the very people they are attempting to help. "We are able to win a battle once in awhile, but the ultimate goal (allowing disabled people the right of controlling their own lives, and being able to make decisions for themselves, and being able to take risks without constraints) can only be won if we work together...on common issues without having to lose our own identities. We have to drop our barriers and learn to trust each other...not only in the different disability groups, but also in the consumer and professional sphere."

"Parental relief that emphasizes natural relationships and provision for parent support are essential to cope with a family member with a disability."
St. Albert Association
for the Handicapped

In 1973, Alberta created the first consumer-controlled provincial organization "of" persons with disabilities — The Alberta Committee of Disabled Citizens — to speak on their own behalf. Other advances have been made since that time — most notably, the Premier's Council on the Status of Persons with Disabilities.

"Speak for the right of persons with disabilities to speak, but do not speak for them."

"It is recommended that community programs should provide support and education to help these community members to relate in a manner that is both beneficial and acceptable to the mentally ill person."
J. de Cangas

Persons with Mental Illness: One in every eight Canadians suffers from some form of mental illness ranging from emotional problems to severe disabling illness. The stigma of mental illness is difficult to shake so this group of individuals continues to suffer from social isolation, family breakdown and an inability to direct or control their health care decisions. This is particularly so for people who have more than one problem, such as both a mental illness and a mental handicap.

Attempts have been made to move people with mental illness from institutions into the community where — without adequate preparation or support mechanisms — they are confronted with multiple hurdles before they can obtain the required support services. This can prove impossible for many — so they end up not receiving the needed community support services, and face the risk of being returned to restrictive or institutional care. In their presentation to us, people with mental health problems indicated that "barriers to community begin to increase as soon as the person enters our mental health system to seek help", and that "...the person is almost an afterthought." Their definition of "community" is a sense of belonging.

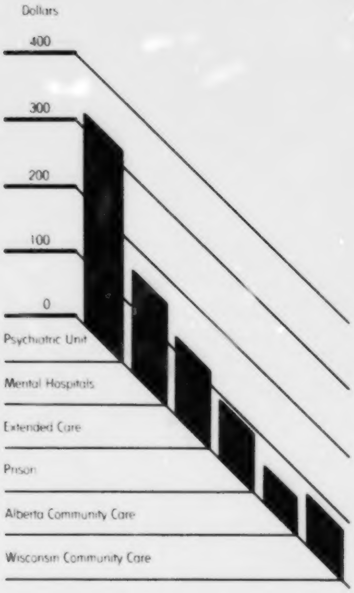
"It is recommended that further development of self-help associations should be encouraged. We hope to pursue a valued relationship between the self-help and professional components of our mental health network."
Calgary Regional Psychiatric Services Planning Committee

Alberta should look at the Dane County (Madison, Wisconsin) model as one of North America's most highly-reputed community support programs for persons with mental illness. In the past three decades, new techniques have been developed to reduce the disabling symptoms of patients; the Prevention of Institutionalization Project proved the feasibility of treating chronic patients in the community and provided them with greater autonomy; and the Training in Community Living model rationalizes community treatment as a viable alternative to hospitalization. As a result, 75 per cent of the people with severe mental disabilities live in an independent setting in the community, and 83 per cent of the mental health dollars are directed to community-based services.

More than 200,000 Albertans suffer from a variety of mental disorders. Most are treated by physicians and psychiatrists and by the government's Mental Health Clinics.

The Commission heard from professionals and consumers alike that funding is heavily biased toward institutional care, yet in reality this is not where most clients receive treatment. Philosophically, it is not where they *should* receive treatment. Indeed, more than two-thirds of Albertans suffering from mental illness are treated in the community and less than one-third in institutions. The allocation of funds, however, is out of balance with this distribution — 88 per cent of the mental health budget is spent on institutions and only 12 per cent is directed toward community mental health services.

Average Cost of Mental Health Service Per Client Day — 1986/87



Source: Department of Health & CMHA Alberta

By the same token, the newly-appointed Mental Health Patient Advocate, according to the position description, will be responsible for investigating "complaints from formal patients detained in designated mental health facilities." "Formal" patients — those in the care of an institution — have gained a voice, despite the fact that twice as many mental health patients reside outside institutions as do inside. The Advocate's position, reporting to the Minister of Alberta Health, was created and recruited to in late 1989.

The Commission would urge that the Advocate's role be reviewed and expanded. Persons with mental illness, trying to function in the community with independence and dignity, desperately need someone to hear their concerns and present their arguments. If not the Mental Health Patient Advocate, who then will advocate for their rights and protection?

Ninety-six per cent of the private mental health professionals live and work in the cities of this province. Albertans living in rural areas who require the specialized services of these professionals either have to go without or relocate to urban centres away from their homes, families, and their natural social support systems.

"The Mental Health Act should also consider the special needs of rural Albertans in terms of their conveyance and accessibility to specialized resources."
Calgary Regional Psychiatric Services Planning Committee

It should be noted that rural Albertans with physical or mental disabilities are exemplary in their ability to create natural supports within their communities. It is not unusual, for instance, for a person with a handicap to work in a local library or help out on the neighbour's farm. Rural communities tend not to over-program people who are in need of support. However, the situation becomes more difficult to manage when people require highly technical medical and psychiatric services.

In order for individuals to assume greater control of their lives, the available dollars need to be reallocated to develop opportunities for people to live with maximum reliance on the resources found or created within their natural environment, and with minimal reliance on institutional services. If, and when, individuals are removed from their usual settings, they should be assisted in returning as soon as possible.

"It is recommended that commencing immediately, more comprehensive planning for mental health service be undertaken at the local, regional and provincial level."
Calgary District Hospital Group Board of Trustees

The people who addressed the Commission repeatedly asked for more coordinated mental health policies, programs and regional services. They told us that "mental health services and health promotion activities are strengthened when those whom they are intended to benefit participate in their design and implementation". They highlighted the need for more education and mental health promotion on how community life can be improved, mental well-being enhanced, and social problems reduced.

"It is recommended that curriculum and school programs should play a role in helping children to gain a sense of worth, experience joy in living and develop values."
M.A. Shone; S. Forbes

They stressed that early identification and intervention programs in the community through public education, public health, and child welfare programs would allow us to deal more effectively with mental health problems. This is particularly important for our children, since youth who manifest mental health problems at an early age are at extremely high risk for disorder and difficulty during adulthood.

A joint conference was held with a large number of mental health consumer and provider groups. One major discussion at the conference centered on the complete integration of mental health and illness approaches with physical health and illness, such as currently occurs to a variable extent in general hospitals. This would reduce the stigma associated with mental illness which isolation in separate institutions serves to exacerbate. Conference participants acknowledged that such a transition would take a long time, but agreed it was a worthwhile target.

The Social Action Committee of the Canadian Mental Health Association, Southern Alberta Region, presented a brief to the Commission entitled "Beyond Acceptance." It is a moving testimony to autonomy and dignity, personal responsibility and community support networks. Throughout it epitomizes the concept of all of us and some of us, but most notably in the following statements: "...the person in the centre...could be anyone of us at any time, whether as a user of mental health services, family members, care-giver or volunteer. In a lifetime, we probably will experience all of these". The title page reads:

> *BEYOND ACCEPTANCE*
> *I want, what I think all people want,*
> *and that is to be accepted, understood,*
> *respected, and loved as I am.*

PEOPLE IN COMMUNITIES — CARING AND COPING

Some of us must cope with health problems. For the vast majority of us, it will mean locating and finding ways of dealing with minor acute illnesses or injuries in a way that is most convenient and effective for us while conserving scarce medical resources. We'll have to continue to handle more common health problems on our own: tolerating colds, doing first aid, lowering our demands for drugs, and using our medical resources more appropriately.

For a number of us, it will mean coping with altered health states and disabilities, hopefully managing the ongoing costs and services of chronic illness or disability such as attendant care and homemaker services to prevent premature institutionalization.

For many, it may mean taking personal control of pain that is constant or never far away. Much of society views pain as an unnecessary accompaniment of illness or injury that should be eliminated 'now'. Living in altered states created by pain killers — in fear of possible addiction, subsequent withdrawal, and a return to pain — may lead some of us to find different ways of managing our own pain and discomfort through pain clinics, complementary therapies, or self-administered medications.

We have a wide array of private practitioners, government agencies, non-government agencies, consumer-controlled agencies, and both private and public institutions to assist us in meeting health care needs. Unfortunately, many community programs, with their limited resources, are considered uncoordinated, redundant or insufficient, and fragmented.

There is an increasing interest in the potential of the small specialty treatment base within the community, but outside the institutional model of the hospital. Part of this interest lies with community treatment options for people with such problems as disabling conditions, substance abuse, mental health concerns, and brain injury. These people require specialized short-term treatment, as well as long-term follow-up and rehabilitation and support. The community option is likely more compatible with people seeing themselves as independent and part of the community.

Over the years, we have developed expectations of our physicians and other health practitioners which may be unrealistic. Some things we could and should learn, with some support, to do ourselves. As well, the current health system has made it difficult for practitioners to meet certain of our needs in what we perceive to be the most appropriate manner.

"It is recommended that there is a need to develop in people a greater sense of effective participation in the decisions which affect them at home, work, school, politically, socially and environmentally, i.e. people who recognize the political nature of life and want to contribute (Healthy Communities)."
Healthy Cities Association — Calgary

"We advocate a much greater emphasis on community and home care programmes. We believe such programmes should exist outside the control of hospital administrations."
Alberta Society of Friends of Medicare

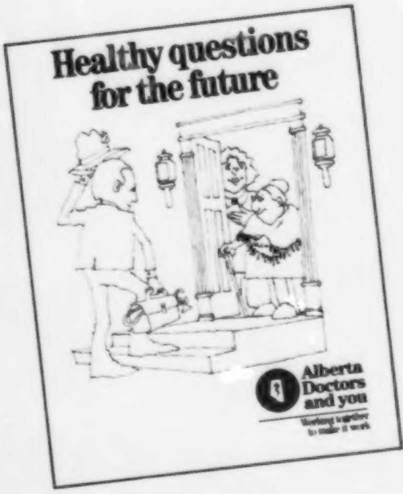
"It is recommended that there be establishment of 'Walk-in Clinics' as an effort to relieve the long waits in emergency rooms and doctors' offices."
E.V. McCouty

Many of us prefer to have medical intervention available when it is convenient to *us* — witness the emergence of walk-in multi-purpose health clinics during the past decade. Based on market demand, the clinics meet a very real need by not requiring appointments, and staying open long hours, seven days a week. While more convenient and less frustrating to the patient, treatment may be given without extensive knowledge of patients' histories or follow-up. The clinics also have affected our traditional relationships with family physicians. Years can go by before we visit the family doctor — usually prompted by a serious problem — but we may have visited walk-in clinics or emergency departments of hospitals dozens of times in the interim. This is particularly true in urban Alberta.

"Walk-in clinics are a source of increasing costs to the tax-payer, with their inappropriate use, and duplication of treatment."
C. Turner

This demand for the quick and visible cure has led to an increased reliance on the use of drugs, and placed additional pressures on physicians to become 'Dr. Fix-it'. Severe strain can result when physicians become caught in the conflict between the kind of practice they feel is needed. and the need to cover the expense of running an office and making a living. It is more lucrative and less time-consuming to prescribe tranquillizers to five patients than to discuss how a widow can overcome depression related to loneliness.

The current payment system, coupled with time constraints, discourages doctors from making house calls in emergency or terminal circumstances, particularly in larger urban centres where patients could live in any corner of the city, great distances from the doctor's office, home or hospital. If terminally ill patients choose to die at home, it is difficult — even rare — to find a doctor who is prepared to visit the home to monitor progress, adjust medications and treatment, and sign the notification of death certificate. Of total physician services in 1988, only 1.4 per cent were for home visits.


Healthy questions for the future
Alberta Doctors and you

When diagnosis is obscure, or treatment complex or ongoing, we expect our doctors to be our advocates and *coordinate* our care. However, physicians, because of the regulations of the College of Physicians and Surgeons of Alberta, are discouraged from referring patients to some complementary health practitioners. Cooperation among accredited practitioners must be encouraged, not restricted. The intelligence and competence of providers and consumers should not be limited by regulations and opinions from the past.

Actually, we have reached an important crossroads in health care. Because of our aging population, and the growing numbers of Albertans surviving life-threatening conditions, more illness and disability is accounted for by disease or impairments of long-term duration than ever before.

While few would challenge the effectiveness of our illness care system, or the release of personal control in hospital while conditions are being stabilized, many have challenged the continuation of institutional approaches when the acute or 'sickness' stage has passed. Extension of hospital routines for ongoing conditions can generate withdrawal, dependencies, segregation, and a suspension of personal control.

"It is recommended that the family be supported through the coordination of support groups and increased funding and emphasis being provided to permit the elderly to remain in their homes as long as possible and maintain their independence."
Big Country Health Unit

Elderly persons are particularly vulnerable to this. Many are admitted to hospital for treatment, but remain because they cannot obtain the support to follow treatment procedures at home. While in hospital, they can lose the ability to care for themselves, and find they must depend on others for assistance with bathing, feeding and other daily living skills. Due to lack of community alternatives, long-term placement then becomes a reality for families.

Our response, as a society, to the growing number of Albertans with ongoing health needs has lacked a coherent vision, mandate, or funding mechanism — not out of malice, but through default. Our long-term care facilities are caught serving as alternate homes, while emulating, in some respects, acute care hospitals. Community services are scattered and dependent on volunteer commitment and short-term funding. Government programs, while innovative, are fragmented, sometimes contradictory and competitive rather than coordinated, and faced with limited resources to cover increasing demands.

"Community-based programs have not been adequately funded — expenditures in this area have not kept up with the inflation rate and at one point — expenditures were even cut back. Too much money is spent on building institutions."
Alberta Council on Aging

One method which has proved very successful is the quick response teams in operation in British Columbia. These teams screen the admission of older patients, determine if they can be cared for at home and then make arrangements for home care. When admission is required, older people need immediate, active and aggressive treatment with an emphasis on rehabilitation, early discharge and continuing support.

"Encourage and fund a computer linkage network for the exchange of drug information, patient information and professional information."
Faculty of Pharmacy and Pharmaceutical Sciences, University of Alberta

If we are to create a strong community base, we must create a new, effective and equitable strategy to provide assistance to the growing numbers of people who must learn to manage and monitor ongoing conditions within a model that promotes personal control, responsibility and dignity, and family integrity.

People with relatively stable conditions, such as spinal cord injuries or cerebral palsy, need access to rehabilitation resources to keep fit and agile. It would be advantageous to lessen the problems associated with lack of activity, reducing the need for costly medical services.

"Mechanisms must be established with a specific mandate for rehabilitation. Those within the field are the ones who must improve this situation."
Glenrose Rehabilitation Hospital

Generally speaking, people with moderate disabilities can work in competitive employment, at full wages, if they receive intensive support initially, and follow-up on a decreasingly frequent schedule for one to two years.
The Premier's Council on the Status of Persons with Disabilities

SENIOR STUDIES INSTITUTE

LIFELONG LEARNING-
RESPONSIVE TO THE COMMUNITY

Grant MacEwan Community College

People with progressive or unstable conditions, such as heart and lung diseases, diabetes, and multiple sclerosis, need access to community-based resources to help them monitor and manage their problems. When treatment is needed, it should be within the reality of their conditions through physician-based clinics with a range of non-medical alternatives, or specialty clinics.

Simply put, people with ongoing conditions need to know how to carry on activities of daily living that fit their health problems in the healthiest possible way. They should be allowed to choose those options which work best for them.

The Commission sees an opportunity for the development of manpower training schemes that can respond to the ongoing needs of persons in the community. The specialties related to developmental disabilities, ongoing community rehabilitation, or aging have been overshadowed by the high tech, fast turnover, and high status specialties related to sports medicine and trauma.

If we are going to establish a community base for ongoing needs, we will require special incentives to attract students. This may involve specialization within our current professions, fostering new professions, and use of alternates, such as peer support.

In the final analysis, treatment and support should be the most effective and least intrusive.

> *"(If) the intervention is of a type which clearly needs the highest level of resources to ensure success, well and good. But if very highly trained and high-priced personnel and/or complex and expensive equipment are being used to provide 'reassurance to the worried well', or in circumstances where emotional support by 'informal' caregivers is more appropriate (and as or more likely to be successful), then the high-priced interventions represent simple waste."*
>
> *The Canadian Institute for Advanced Research*

INDIVIDUALS IN CONTROL

Somehow, the vision of the ideal health care system appears to have blurred. Within the health care system, "the system" now seems to focus on itself. In fact, the system is meant to serve the people — and certainly individuals who work in the system believe they perform their duties in the service of individuals...providing care, relieving pain, and giving comfort. Yet, both consumers and providers have become entangled in the bureaucratic web of the highly complex and complicated health care system. Too often, programs are established with the best of intentions for individuals — but administered with little regard for the needs of that specific individual, while also limiting the flexibility and creativity of the providers to respond on an individual basis. The saying of Alexis de Tocqueville, "Every central government worships uniformity; uniformity relieves it from an inquiry into an infinity of details, which must be attended to if rules have to be adapted to different men, instead of indiscriminately subjecting all men to the same rule," seems to fit.

"It is recommended that, for purposes of operations, the responsibility for decision-making should be placed as near as possible to the point of delivery."
H.L. Morrison

In the past, when we developed an illness, had a disability, or required health care services, we were considered "sick", and assumed to be less capable of making well-informed decisions about complex, or even simple issues. As a result, medical information was often kept from us and decisions were made on our behalf. There was no real plot or conspiracy to stifle the patient in the decision-making process. The medical profession, possessing the knowledge and expertise, accepted the larger portion of the burden of treating illness...sparing us the anguish of coping with unfamiliar medical terminology and treatment procedures. We lacked the knowledge to judge or weigh what should be done in our own best interests, preferring that the experts decide.

What has happened to change our relationship with health care providers? Knowledge. As more information becomes available, awareness and understanding among us increases. We want to be in the position of making informed choices about the options available to us in regard to our health care needs. We want to be involved as partners with caregivers in determining who will provide treatment, what that treatment should be, where it will occur, and how much intervention we are willing to accept. We, as individuals, want to be in control. Some of us are prepared to put ourselves at "dignity of risk" — we believe in our right to choose, to refuse treatment, to take our best chance.

"Many patients feel a lack of control upon their entry into the health care system, but there is a trend that demands individuals take care of their health. What can be done to make patients feel that they still have control?

Educating potential patients so that when they enter a hospital they are informed about their illness, possible treatments, etc. this makes it possible for them to feel that they have more control over their own health decisions."
Alberta Hospital Association

"It is recommended that there be open referral, so different practitioners can begin to assess the efficacy of each other's therapy for particular complaints."
A. Chan

The Commission recognizes that the transition from dependence to independence to mature interdependence will require certain changes in attitude among both health care providers and consumers. Some providers will feel threatened...some consumers will approach their new authority with caution. Many will welcome the opportunity to share the responsibility and accountability for decisions with enthusiasm and, perhaps, relief.

The word that best describes the emerging role of Albertans is *empowerment*...returning the *authority* to individuals to make decisions about our health — about living and dying. All of us, at all times must be respected as individuals who have a right to dignity, privacy and autonomy...to exercise maximum control over our destinies.

The recommendations and directions for implementation in this chapter were developed to empower Albertans by redirecting responsibilities to people — the *real* focus of health care and health care systems.

Our health information

In the past, we have relied on physicians to keep and interpret our medical histories, and to explain our illnesses in the context of our medical past. Our records — compiled in a language unfamiliar to us — remained isolated in files in doctors' offices and hospitals, and were sometimes transmitted between doctors and institutions without our knowledge. Our relationship with the medical profession centred around the family physician whom we knew and trusted. We chose to accept a dependent role: physician/patient closely resembled parent/child models.

"It is recommended that, as one way for the health care system to save money, patients should keep their own records of their health problems as written down or diagnosed by their physician."
C. Selwood

Today, we are a mobile society. We move from farm to city, from city to city, from province to province. For convenience, we visit neighbourhood walk-in clinics. Our doctors and other care providers change, but our records remain in each office and hospital we have visited. When we seek new practitioners, we provide them with our laymen's interpretation of our medical past. To us it has not mattered whether the fracture was the ulna or the radius...to us a broken arm is a broken arm.

More and more, we want — indeed, need — access to accurate and complete records of our health histories, and we want to know more about what it all means. We understand the issue of confidentiality of information, but we no longer accept being excluded from information about our personal health care — we want access to our information, we want control over it.

Increasingly, health, social service and education records, and personnel files, are open to us. As more information becomes easily available to us, we need to be able to understand and manage it. Fortunately, most doctors and other health practitioners are taking the time to explain medical problems and options to us so we can be more directly involved and give appropriately informed consent to diagnosis and treatment.

"Consumers should have the confidentiality of their health records guaranteed."
Consumers Association of Canada (Alberta)

But control of our own health information continues to be an issue. Health professionals may believe information about certain diagnoses, such as some infectious diseases or psychiatric conditions, should be made available to protect others from potentially dangerous situations. However, a person — one who has AIDS, for instance — may wish to keep that diagnosis confidential.

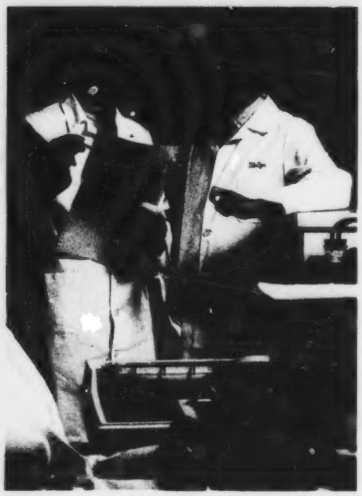
The special project committee of the Alberta Branch of the Canadian Bar Association recommended to the Commission that legislative change to the Hospitals Act is necessary regarding health care information and documentation. The committee suggested that the procedural onus be reversed to require the record keeper to disclose the record to the patient, unless that record keeper has applied for and obtained an order of a judge of the court directing that access be withheld.

The Commission believes that personal health information must be made available to all Albertans on personalized, portable, and confidential micro-computer cards or other devices. The foremost consideration is to put the individual in greater control of information, but such a system would provide several other advantages and facilitate a variety of applications.

The storage capacity of new electronic devices such as "smart cards" can easily accommodate an individual's full health history confidentially, including all medical/dental/pharmaceutical records, X-rays, other technical data, and insurance information. Portable health records would provide a partial solution to avoid duplicated investigation and medication.

"Interactive information entry and retrieval, smart card technology (or something of that kind) should be used to facilitate a portable record of patient history, current diagnosis, and current active treatment."
Independent Physical Therapists of Alberta

Currently, the lack of adequate information transfer results in duplication of services when we see several providers regarding the same health problem. The manual system needs to be regularly updated, and is inefficient due to duplication of data. It cannot be used readily for monitoring utilization and quality control, or identifying abuses of the system by providers and patients.



3.0 **THEREFORE, WE RECOMMEND that the Government of Alberta establish a committee in 1990 to develop a strategy for the implementation of a system to collect, transfer, store, and update individual health data which can be accessed through personal microcomputer devices;**

3.1 that the committee be represented by Alberta Health, the health care professions, the Advocate for a Healthy Alberta, the Health Authorities, health care and post-secondary institutions, and other departments, organizations, and the private sector as appropriate;

3.2 that the strategy include the selection of a suitable area, ideally within a Health Authority boundary, which would participate in a full pilot project to test province-wide application;

3.3 that the strategy include a proposal for financial and/or manpower incentives to assist and encourage Health Authorities and health care institutions and operations such as doctors' offices, community health clinics, and others, in making the transition to a province-wide, compatible, confidential, computerized system;

3.4 that an awareness program be developed to encourage, inform, ensure and/or train health care providers and consumers in the use, advantages and confidentiality of the computerized system; and

3.5 that the personalized, computerized health care information system be phased-in and fully operational throughout the province no later than 1995.

Directions for Implementation

Given that Alberta Health has begun to explore the possibility of using a secure "smart card" system and that the recommendation itself is straightforward and detailed, few comments regarding implementation are necessary.

Important to the success of the transition will be the cooperation of facilities that provide health care services and their ability to transfer and convert information, much of which is already stored on a variety of computer systems, to a compatible, confidential format and universal database. In order to meet the target date, a number of programs of assistance may be required.

Despite wide-spread availability of computer card machines which accommodate banking transactions, for example, many people currently do not avail themselves of the convenience. Whether this is the result of a preference to deal on a face-to-face basis or mistrust of "machines", it should serve as a signal that awareness programs must be a vital component of the overall concept. Despite the desire to exercise greater control over personal health information, many people may need to be reassured of the confidentiality and security of the system.

"It is recommended that, with respect to the technology becoming available permitting patients to carry their entire medical history (including a record of their health service utilization) on a plastic card, this record should be read and updated by practitioners and it could be copied for their own records. It could contain records of prescriptions and pharmacies could use it to avert adverse drug interactions and monitor drug abuse."
R.D. Hamm

Consumer knowledge and skill development

Once armed with our personal health records and provided with greater options regarding health care providers and treatments, we must ensure that we possess a level of knowledge sufficient to allow us to use the health care system wisely and responsibly.

Through Town Hall meetings and talking to the public at large, it became clear to the Commission that there was little knowledge at the consumer level concerning actual costs and range of services in the health care sector compared to the knowledge of costs and services that we pay for directly in other sectors. To a large extent, it would appear the Alberta Health Care Insurance Plan acts as a shield against the reality of how expensive medical and hospital services are, and that the majority of the funds come, not from premiums, but from taxes. With more detailed information, consumers might be more judicious in their use of services and less demanding on the system.

"We need to educate our population as to the costs of health care."
M. Krawiec

Additionally, our children need to know how to make informed decisions about when and how to use the health and health care system effectively, efficiently and economically. Our future will be enhanced by knowledgeable generations who appreciate the value of the system and understand the services it provides.

Teachers can be influential and helpful on a number of health fronts — by knowing what constitutes healthy behaviour and by recognizing symptoms of problems among students; and by being familiar enough with the health care system to recommend appropriate services, to incorporate aspects of the system into a variety of classroom discussions, and to teach responsible use of services. Teachers should be supported by administrators in working with young people in ways that facilitate mental health and management of stress, and encourage healthy lifestyle practices. They need to develop greater insights about how children think and respond at each age level.

Equality for persons with disabilities may require extensive modifications and even costly accommodations, but that is the price of a democracy. Citizens with disabilities want what all citizens receive from their government; no more, no less.
Jerome Schein, Peikoff Chair, Deafness Studies, University of Alberta

"It is recommended that community-based, community-run services be further encouraged with self-help groups given greater emphasis, facilities, support and networking opportunities."
Red Deer Regional Mental Health Council

"It is recommended that the Government of Alberta reconfirm its policy that community participation is a fundamental requirement for an effective and efficient primary health care system."
Sturgeon Health Unit

As consumers, all of us need to be aware of health care options and services available to us and how to access them. For the most part, we use families and friends as a first resource to find out what is available. With the increase in programs and community action facilities, the family practitioner may be less aware of options available outside the traditional medical system than formerly. Indeed, the Commission wonders whether the medical practitioners, given the enormous time required to keep up with conventional medical care information, are the most appropriate people to provide information on alternatives or community supports.

A number of facilitator organizations are currently in place or planned to provide consumer information about health and health care problems and services. The Calgary Association for Independent Living (CAIL) provides information on how to hire attendant care and how to gain access to daily living services. The Easter Seal Ability Council of Alberta, and The Premier's Council on the Status of Persons with Disabilities, and other groups provide information specific to people with disabilities. For senior citizens, countless groups or resource centres like the Kerby Centre in Calgary, the Strathcona Place Society in Edmonton, and most drop-in centres in rural communities have information available. Many other voluntary groups, private sector agencies and government departments provide information — *the problem is not a lack of information, the problem is knowing how to get it, where it is, and what it means.*

For this reason, new ways are emerging to support us in understanding and using information. Some of the more popular include information centres and phone-in services related to specific health issues which are manned by people who are personally familiar with the conditions or issues. There are an increasing number of self-help groups that can provide a knowledgeable network of people who have experience dealing with specific health issues. These groups can help identify and evaluate options, and provide support as to which might be most useful. Also, pre-packaged videos, recordings and computer programs assist individuals and families to understand specific conditions, practical first aid and treatment, operative and dental procedures, and health and social problems. These are being used increasingly by hospitals, practitioner offices, volunteer agencies, and employers to explain and reduce the fear of the unknown.

4.0 THEREFORE, WE RECOMMEND that during regular curriculum review, matters pertaining to the health system be included in appropriate life skills management, social studies, and other courses in the school curriculum, and that the incorporation be concluded no later than 1995;

4.1 that health studies at Alberta's post-secondary institutions include courses on the use of the health system;

4.2 that information on the costs of services rendered by practitioners, institutions or government agencies be provided to individuals;

4.3 that the Government of Alberta initiate methods of informing its constituents of the range of health services available, how and when to use them, where the funds come from, and their value; and

4.4 that incentives be provided to Albertans to maintain a healthy lifestyle, and some form of reward be provided to those who use the health care system significantly less than the norm.

Directions for Implementation

The elements of this recommendation are based on the need for immediate and ongoing change in the health and education sectors. Some cooperation among departments of government already exists in areas of health personnel education, and elementary and secondary school curricula and activities. This will have to be further extended to accommodate consumer skill-development in health and health care.

"It is recommended that we must ultimately achieve a culture which values, as a social and political norm, exercise and the attainment of a healthy, vigorous lifestyle so that we may all die young — as late as possible."
Alberta Recreation and Parks

In order for consumers to make informed decisions regarding selection of options and, more generally, becoming aware, statements of actual and total cost of treatment should be provided by whoever provides the service.

People who maintain healthy lifestyles — do not smoke or drink, and are not overweight, for example — might be rewarded with lower health care insurance premiums, or recognized for their achievement in other ways. Developing a "Health Report Card for Albertans", with goals set by the consumer and the health care provider, might be a useful effort of direct personal involvement. The Commission wishes to stress that such an incentive program would not penalize people who, because of ongoing illness or injury, legitimately must use the health care system more than the norm. Indeed, any number of these people would also qualify for rewards and recognition. However, there may be some circumstances which do warrant some punitive action — for instance, persons who are convicted of impaired driving offences, in addition to other fines, might be required to pay higher health care insurance premiums.

"It is recommended that where patients choose to indulge in lifestyles obviously deleterious to their health, they be required to pay increased AHCIP premiums."
Alberta Medical Association

"My mother finally died last week, what was left of her enduring over 13 years of inhuman existence. Her body lived in Unit #3, South of the Good Samaritan Auxiliary Hospital in Edmonton. She lived in a persistent vegetative state after unsuccessful surgery following a ruptured berry aneurysm.

I strongly feel that active euthanasia under certain circumstances is highly appropriate. I believe it should be done by committee when either the family spontaneously requests it or when they arrive at this decision after the hopelessness of the condition becomes apparent and they are so advised. I believe it should be done with an Ombudsman acting on the behalf of the patient, with a designated family member, a representative of the hospital, a clergyman or ethicist from the hospital or perhaps the province (state), the personal physician of the patient, and a senior or designated member of the medical staff. Such an arrangement safeguards the rights of the patient and relieves the family of the guilt associated with so momentous a decision."

Joe Freedman

Difficult decisions

Within the next 50 years, we can expect to discover technologies that will prolong a person's life indefinitely. Will we know how to use that technology? Will we be able to afford it? What constitutes a life? When does it begin? When does it end? Should it end?

As individuals and as a society, we need to discuss and make decisions on these difficult issues — firstly, for ourselves and secondly, because our answers will affect our health care system and how we spend our resources.

At a personal level, we may face having to make any number of decisions. Do we continue with a pregnancy that will give birth to a child who is severely handicapped, institutionalize a loved one who cannot live on their own, continue heroic treatment when a person shows no signs of understanding? In all of these situations, we and our families and our health care practitioners find ourselves caught between the possibilities of medicine and personal beliefs.

In the past, difficult decisions — sometimes less complicated than those today — were made by family members, or between families and physicians, and often within the context of our religious beliefs. More and more, decisions about our health, or our death, are now made in fear of court action, malpractice suits, hospital policy, and public presentation. It seems that increasingly we are not the arbiters of our own destinies.

Quadriplegic Given Right to Die — Report from Atlanta granted a 33-year-old quadriplegic man's wish to be allowed to shut off the machine that has kept him alive for four years. Judge in doing so ruled that McAfee's right to refuse life sustaining treatment outweighed the state's interest in preserving life. McAfee asked the court's permission to shield anyone who helped him from potential legal problems. The Edmonton Journal, Sept. 8, 1989

Religion, as the reflection of our beliefs about life, has been a major source of support when difficult decisions had to be made. However, with the increasing complexity of medical decisions, physicians find themselves pulled into helping us make these difficult decisions, and religion and personal beliefs seem to play less of a role. Perhaps this is because so much more can be done to keep us alive, even though we may be brain dead or totally incapable of quality life.

The Commission is not in favor of active euthanasia. Neither for instance is the Canadian Medical Association among others. However, the general question of euthanasia must definitely be raised in this context. In California, there is a bill before the state legislature that would permit mercy killing by lethal injections. In Holland, an estimated 5,000 people a year choose to die in hospitals by euthanasia. Around the globe, a pro-euthanasia group called the Hemlock Society is gaining support. A Gallup poll conducted in 1989 shows 77 per cent of Canadians believe doctors should be permitted to terminate the lives of incurably sick people who are suffering greatly and who want to die.

"It is recommended that the primary decision-maker is the patient. The patient's decision to undergo treatment, to refuse treatment, to strive to live or to seek to die is primary."
Alberta & North Synod
Evangelical Lutheran Church
in Canada

In addition to the counsel provided by social workers, psychologists, psychiatrists, and nurses, the specialty of pastoral care has emerged to help people make difficult decisions. Specialized multi-disciplinary and non-denominational training is provided through programs accredited by the Canadian Association of Pastoral Education. Specialists work through places of worship, in hospitals, in extended care facilities, and within communities to reach us when we need support and guidance in making difficult decisions about ordinary care, the refusal of treatment, or timing of the "moment of death."

"Pastoral care must be officially sanctioned by the government through its inclusion in the funding for hospitals."
St. Mary's Hospital — Camrose

The Commission supports efforts to include pastoral care units as part of hospital budgets. Denominational support within hospitals reflects each denomination's right and responsibility to those of its particular faith.

Individuals, families, and health professionals could benefit from discussions with professionals trained in medical ethics. Emotionally laden issues, and deeply held moral convictions, often lead to poor communication, especially in fast-paced institutions. Ethical issues — withdrawing life support, organ transplants from infants or emotionally related donors, or parental consent to surgical sterilization of a dependent adult — rarely admit to an easy or clear solution.

Nurses and other health providers, who may not have participated in medical decisions, may be asked to carry out procedures to which patients, families, and physicians have agreed, but about which they have little or no understanding or knowledge. An ethicist, sensitive to providers' roles, may be of help in clarifying the issues and finding common values on which to base either the decision or a health professional's involvement with a controversial choice.

"It is recommended that the provincial government specifically encourage health care institutions to adopt practices which will enhance an ethical approach to the allocation of resources, such as an active and involved interdisciplinary bioethics committee."
Grey Nuns of Alberta

"It is recommended that every consideration for some type of government funding should be given to an ethics 'think tank' similar to The Hastings Center in New York."
J. Storch

"The future must be focused on providing a true 'health' care system for the people of this province. One which provides a basis by which each individual can participate in and take responsibility for his/her own health needs."
Staff Nurses Association of Alberta

Hospital boards are required to address the need for policies on informed consent, patient choice of treatment, refusal of treatment, accessibility to treatment, withholding treatment, restraints, abortion, and other matters related to bio-medical ethics. Hospital staff need support to understand and implement policy. Educational facilities singly, or in cooperation with health delivery facilities, are setting up formal groups to educate and to act as a resource to professionals. The Medical Bioethics Research Group and the Calgary Institute for the Humanities at the University of Calgary, and the Joint Faculties Bioethics Project at the University of Alberta are examples. As well, St. Joseph's College Centre for Ethics in Health Care and Biology is a first for Alberta, and began operations on September 1, 1989 in Edmonton.

"What difference does the Center make? A significant one we believe. Hastings Center staff members have testified before a wide range of state and federal legislators; have assisted in the drafting of key legislation; and have served on such diverse groups as Congressional Office of Technology Assessment Panels, state commissions, and National Academy of Science Study Groups.

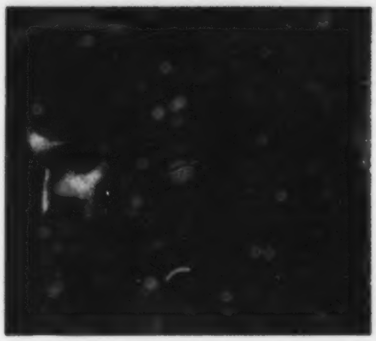
"The Center's reports and publications have been a mainstay in the field of medical and professional ethics. Its guidelines have helped to orient practitioners and shape policy. Its consultative work has informed the media, professionals and the public." — Hastings Center, 1986

Basically, five concerns are at the core of the dilemmas in health and health care: consent to treatment; treatment of the aged and the newborn; allowing patients to die in palliative care settings; confidentiality of patient information; and health resource allocation, that is, rationing scarce resources.

A number of centres, institutes, and groups are attempting to provide resource material, discussion, advice, and education in the area of ethics and decision-making in health care. It is clear that the need exists for a well-funded, overall body responsible for education, consultation, and research.

This body could help all of us deal with difficult decisions and dilemmas in health care as they arise. Its debates and studies would involve consumers, providers, government planners, pastoral care specialists, the judiciary and policy makers. Its opinions and findings would be communicated to the public and all interested groups in an understandable, meaningful, and timely manner.

5.0 **THEREFORE, WE RECOMMEND that the Government of Alberta support the establishment of a provincial Ethics Centre by providing matching grants annually, up to and including 1995, to funds provided by academic institutions, religious groups, corporations, foundations, and individuals;**



5.1 that the Ethics Centre exist within an intellectual but practical environment, accessible by the public, but operating at arms-length from governing bodies;

5.2 that the findings of the Ethics Centre be shared with Albertans in an appropriate manner, with provincial Health Authorities, with members of health care and other professions, and with similar centres nationally and internationally; and

5.3 that the success of the Ethics Centre in meeting its mandate be reviewed in 1994 to determine continuing the Government of Alberta matching-grant program for an additional five years.

Directions for Implementation

The establishment of an Ethics Centre could be based on the already firm foundations of the activities at the Universities of Alberta and Calgary. St. Joseph's College could provide useful advice.

The objectives and goals of the Ethics Centre would be to:
— provide an accessible resource for citizens of Alberta in respect to ethical issues in health care and dying through symposia and community outreach programs;
— increase public and professional awareness to ethical issues in patient care, throughout the province;
— facilitate an interdisciplinary approach to the teaching of ethics/bioethics to undergraduate and graduate students in health care professions in post-secondary institutions in Alberta;
— encourage discussion among practising health care professionals and consumers;
— examine issues of hospital and health care administration from an ethical viewpoint and provide advice on request; and
— examine the wider ethical aspects of health care policy and resource allocation in Canadian society.

"It is recommended that institutions of higher learning in Alberta be encouraged to establish research and educational programs in bioethics."
Catholic Health Association of Alberta
Catholic Hospitals Foundation of Alberta

"It is recommended that a task force with representatives of the various professional disciplines involved, the public and service providers, should be struck to review and recommend on legal and ethical policies to be used as a foundation for decision-making in the allocation of resources for long-term care services."

Edmonton and Rural Auxiliary Hospital & Nursing Home District #24

The Commission believes financial support would be forthcoming from a variety of interested institutions, groups and individuals based on a commitment from government. The Government of Alberta should explore the feasibility of deriving matching-grant funds for the Ethics Centre from the Family Life and Drug Abuse Foundation endowment. The funding approaches taken by other ethics centres, such as Westminster Institute in London, Ontario, and Hastings Institute in New York, and St. Joseph's College, should be examined.

Active personal control

Many health care providers, would prefer to expand our opportunities to access treatment, to request alternate treatment or to refuse treatment. However, some professionals are uneasy because we generally have allowed them to make decisions on our behalf believing them to be more knowledgeable. It is easier, and some have said better, to continue that way. Many Albertans want to be in greater control; others want control and the option of a greater number of approved providers.

Whatever the options, we must accept the risks and responsibilities which accompany the right to decide the type of care we receive. Health professionals will be in a better position to facilitate our involvement if we relieve them of the responsibility and legal liability for some of our health decisions.

Currently, we struggle with how to be sure our wishes will be recognized and acted upon if we become incapable of expressing ourselves. There is an undeniable dignity in exercising authority over decisions we can make today knowing they will be followed in the future.

The Dependent Adults Act (Alberta 1981) was created to provide a substitute decision-maker for those Albertans 18 years of age or older who are unable to care for themselves, and who are unable to make personal decisions. This unique Canadian human rights legislation has given a voice to those persons who, because of disabilities such as mental retardation, chronic mental illness, brain damage, or disease associated with aging, are deemed incapable. A guardian and trustee — persons close to the dependent adult or publicly appointed by the courts — are instructed to act in the best interests and in the least restrictive manner in matters relating to medical care and financial management, respectively. The Public Guardian's Office has become the natural ally in the search for more individualized solutions that are in the best interests of dependent adults.

"Increasingly, application is being made on behalf of adults who have been competent through their lives and become incompetent in their old age as a result of a dementing or other illness.

It is recommended that there are a number of policy and legislative issues that should be addressed as more people turn to guardianship by the state."

The General Hospital (Grey Nuns) of Edmonton

Power of attorney is a legal process through which we can appoint another person to act on our behalf as long as we are still able to make decisions. In Alberta, power of attorney ceases when we become mentally incapacitated. People whose mental faculties are beginning to fail frequently wish to grant a power of attorney to a family member or a friend, with the expectation that this will enable our affairs to be managed by our designate after we become mentally incompetent. However, under current Alberta legislation, this cannot be done. Ontario and Nova Scotia have extended power of attorney to cover such situations. Safeguards include requiring more than one witness to the forms, and having the advice of a lawyer before signing the power of attorney.

Enduring power of attorney would provide a relatively informal means of managing ongoing financial affairs of persons. This would allow us, in advance of incapacity, to decide for ourselves who is best suited to handle longer-term matters on our behalf, rather than waiting until the courts make a decision after sometimes costly, time consuming, and emotionally draining legal procedures.

Through advanced directives, commonly referred to as living wills, we could decide ahead of time what actions are to be taken regarding our future health in case we become incapable. Currently, living wills are not binding on providers or administrators because no legislation or law exists in Canada to deal with them. Giving living wills legal status could raise problems if we change our minds or if our families or health providers disagree with our directives. This would be addressed by legislation.

Legalizing advanced directives/living wills ensures that our instructions for specific circumstances are known by others close to us. Substitute decision-makers are far more comfortable with and are relieved of the burden of making decisions in our best interests if they know our preferences. A statute legalizing advanced directives could encourage facilities or caregivers to request voluntary, written advanced directives in history-taking procedures on admission to the hospital, thus recording end-of-life instructions or choices in health care. It must, however, be recognized that even a person of limited competence must be allowed to reject earlier wishes. It is important that the most current wishes of the person be acknowledged to guard against out-of-date directives being followed.

"It is recommended that serious consideration be given to enacting legislation to provide for a substitute decision-maker appointed by the patient similar to that found in enduring powers of attorney legislation in other jurisdictions."

Special Project Committee of the Alberta Branch of the Canadian Bar Association

The introduction of appropriate legislation that will authorize enduring power of attorney would allow our designate to handle our finances for us when, or if, we become incompetent, while living wills would establish the options for treatment or withholding treatment should the need arise.

6.0 THEREFORE, WE RECOMMEND that the Government of Alberta introduce legislation in 1990 which will enable Albertans to provide

1) enduring power of attorney regarding financial and other matters; and

2) advanced directives, also referred to as "living wills", regarding personal matters.

Directions for Implementation

Fourteen years of experience with the *Dependent Adults Act - Alberta* provides a base to study the effectiveness of and needs for safeguards. Initial research in this area has started and must be encouraged to continue.

"It is recommended that, in relation to the patient's right to refuse treatment, coupled with proper care and attention to pain relief, this should allow a comfortable death due to natural processes."
P.G. Winkelaar

Public debate, generated through the Ethics Centre as one of its first tasks, would identify what professionals, and Albertans in general, believe to be important for inclusion in legislation governing both enduring power of attorney and advanced directives. We should have the ability to choose who we want to handle our affairs without losing our ability to take part as long as we can, and in whatever way we can.

The legal aspects of both enduring power of attorney and advanced directives, including fees and registration of do-it-yourself orders, will need to be investigated. Other jurisdictions which have either or both in place could provide useful information to Alberta.

Alberta drivers' licences include a universal donor card giving us the opportunity to donate specific or needed organs, tissue, or parts following death. Once signed and witnessed, the card is legally binding in Canada and the United States without permission from next-of-kin. Decisions about death and dying, including such considerations as organ transplants and life support systems, could be affected by changing technologies and advanced procedures. Keeping end-of-life information current on our personalized "smart cards" would be relatively easy to maintain, and should be as legally binding as universal donor cards.

Self-instruction materials related to enduring power of attorney and advanced directives, developed for use in discussions with family members and health care providers, would be helpful in clarifying positions and outlining legal requirements. The Ethics Centre could be the primary source for gathering and disseminating such information to individuals and local Health Authorities.

Personal portable funding

Currently, we provide payment for our health care through three mechanisms. We pay out of our pockets for a variety of services including dentists, counsellors, psychologists, and others; for appliances such as crutches, trusses and glasses; and for over-the-counter drugs, medications, and merchandise. We may pay for non-governmental third-party insurance such as Blue Cross or other private sector insurance to cover such items as ambulance service, private rooms, and dental coverage. All Alberta residents, through the Alberta Health Care Insurance Plan, are covered for most hospital care, physician care and care by a select group of other providers; and this is paid for through our taxes and health care premiums and other sources of government revenue and borrowing.

Unfortunately, the costs of those services provided through our government insurance program are generally unknown to consumers, and indeed may often be unknown to providers, especially those in the hospital system. Additionally, consumers, having paid for coverage through taxes and premiums, are forced to choose only those services provided under government insurance in order to have them paid for fully or in part by the plan. These shortfalls could adversely affect the Commission's principles of people, choice, change, opportunity, and decisions.

The current funding system for primary practice does not adequately foster an atmosphere that encourages autonomy, responsibility and self-reliance in the utilization of health services. We need a funding structure that will be flexible, and will encourage and reward efficiency and effectiveness on the part of the consumers and providers. More innovative approaches must be adopted to managing the financing and funding of health services, providing us with greater individual responsibility and accountability.

7.0 **THEREFORE, WE RECOMMEND that the Government of Alberta explore the option of a system that provides all Albertans and/or their designates with the responsibility for disbursing, managing and monitoring the funds required for their health care needs;**

7.1 that a system of personalized funding be devised that determines individual/family, annual health care expense budgets (based on past usage, needs, typical comparisons and circumstances) which can be accessed only through personal, micro-computer devices from the Alberta Health Care Insurance Plan account, and can provide monthly statements detailing expenses and available balance.

7.2 that the system be flexible enough to accommodate budget adjustments following changes in health circumstance and confirmation of diagnosis;

"Spending more on health care is both practically and politically feasible if our health care policy, programs, and priorities are effectively and efficiently determined, if health care philosophy and objectives are sound, if they are effectively communicated – and if the public is adequately involved in the process."
S. Stinson

"It is recommended that there should be billing slips for patients given from MDs to the patient who would in turn send in the slip to health care."
O. Jeske

People directly derive personal public health credit by use of their smart cards to pay for health services.

7.3 that the system be tested in conjunction with the pilot project recommended to test the province-wide application of the personalized, computerized health information devices;

7.4 that consumer education programs be developed to assist Albertans in making informed choices about services and care providers; and

7.5 that the transfer of this responsibility to individual Albertans be phased-in and fully operational by 2005.

Directions for Implementation

"One of the major factors that must be clearly identified and honestly presented is the honest disclosure of important issues such as cost.

...If individuals knew what these services really cost, I suspect they would better understand and begin to demonstrate the need for rationing and apportioning very special services."
Dr. R.A. Morgan

The pilot phase for personal portable funding must monitor not only effectiveness of the system but also patient use of health services. Will some of us hoard our credit for a real need and miss preventive measures or early detection? Will we try to spend all credits left at the end of the year? Will we make sensible choices all of the time?

The Commission believes Albertans, by and large, will use the system wisely and appropriately, but recognizes that adequate information will influence informed decisions regarding choices. In essence, the Commission supports the "dignity of risk" which emphasizes that the possibility of us making mistakes must be balanced against removing free and voluntary choice from particular decisions. While such a possibility is not desirable, it may be justified. Furthermore, it is important to recognize that many services — especially emerging alternate care services — may not be suitable for inclusion under personal portable funding unless they are considered basic under the Alberta Health Care Insurance Plan.

The concept must be designed to ensure that point-of-service awareness of cost is available. When the debit card is used to pay for a service, the service provided, its cost and, if feasible, an authorizing signature from the consumer are obtained. The completed transaction should indicate that the provider, the service performed, the cardholder and the amount billed are all validated and acceptable. Finally, electronic transfer of funds from the individual's or family's public health care account to the provider's account will occur immediately. This approach should eliminate cumbersome paperwork on the part of health care providers and government. Albertans — who for whatever reason do not have their "smart cards", or unable, particularly in emergency situations, to provide an authorizing signature — will not be denied treatment or service.

Current mechanisms in place to review provision of services by practitioners, such as the Medical Practice Audit Committee of the College of Physicians and Surgeons of Alberta, should continue, and the same approach be used by other professional organizations whose members are paid from the public purse.

Also, consumer use of services should be electronically monitored so that the number of services accessed and by whom can be identified. For most patients, the need to receive health care services will be obvious. For some, however, there may be an identifiable overuse of the public system and the public purse. Such individuals or families might require counselling about the use of services, and be motivated to take corrective action. Others may have to have their access to the public system constrained by requiring them to attend only pre-determined providers. A similar approach already exists to monitor possible overuse of narcotics. Triplicate prescription forms lessen the chance of one or more physicians over-prescribing drugs to patients who may seek the services of more than one provider.

"There is too many freebies given out as far as the health care system is concerned in Alberta."
B. Dorshied

Finally, the services and providers eligible to be paid through the personal, portable debit card will have to be defined by the government of the day in consultation with providers and consumers.

Basic and supplementary insurance

Recently, the utilization of health care services has become the focus of attention of governments and health care economists. Because of the cost of the health care system, both patients and fee-for-service providers have been blamed for excessive use of the system. In the present system, individuals have the option of directly paying for only a small proportion of health care services. Annual provincial government expenditures currently average more than $1,300 per capita/per year in Alberta.

All residents of Alberta are eligible to be covered by the Alberta Health Care Insurance Plan (AHCIP), but the plan does not allow great flexibility with respect to coverage of treatments and treaters. Although AHCIP is not an "insurance" program in the usual sense of the word, premiums do raise more than $250 million, or about 27 per cent of the more than $980 million expenditure for health care insurance on a user-pay basis. Basically, this is a social program.

"It is recommended that health care premiums should be phased out. The general revenues of the province should be used to fund the costs of the health care insurance plan."
The Edmonton Social Planning Council

Only two provinces, Alberta and British Columbia, continue to have premiums as part of their provincial health care insurance program. It is not well known that residents of Alberta are not to be denied health care if their premiums are not paid. Health care services, which fall under the Canada Health Act, must be provided to all bona fide residents of Alberta. If an individual does not have a current AHCIP number and card, a simple declaration that they are a resident of Alberta and the completion of a Registration/Registry Confirmation form should be sufficient to allow them to receive the service and the practitioner to be paid for the service. However, in reality the absence of a current AHCIP number and card does add to the difficulty of receiving services and practitioners being paid.

In 1989, there were a total of 3,889 registered physicians within Alberta: 2,149 general practitioners, and 1,680 specialists. In addition to physicians, there were 1,075 dentists, 332 chiropractors, 220 optometrists, 21 podiatrists, and 423 physical therapists registered to provide care, and be paid in part or in full through the AHCIP. In addition to those able to bill the AHCIP for services, a large number of fee-for-service health practitioners are paid directly by patients. These include nurses, some surgeons (particularly cosmetic surgeons), counsellors and psychologists, occupational and speech therapists, most dentists, and others. Most of these practitioners are governed by professional associations and many have provincial legislation governing their practice.

"It is recommended that private insurance companies should lead the way in health care by encouraging companies to provide wellness health care for their employees, which would ensure improved health of employees and increased profits for employers."
P. Vipond

Other alternative therapists such as naturopaths, herbalists, Native healers and others, are relevant to improving Albertans' health status within a system that supports choice and personal responsibility, and encourages cultural diversity. Such practices have been in existence in Alberta and elsewhere for many years but are not generally accepted within the framework of traditional health care. Our public payment structure, in effect, creates the impression of two camps: "legitimate" health practitioners who can bill the public purse; and others who cannot.

The Province of Alberta conforms fully with the five-program criteria of the Canada Health Act — public administration, comprehensiveness, universality, portability, and accessibility — and the Commission believes that it should continue to do so.

The Canada Health Act requires provinces, through their health care insurance plans, to cover "all insured health services" provided by hospitals, medical practitioners or dentists; and similar or additional services rendered by other health care practitioners as determined by the province. In so doing the province satisfies the criterion respecting comprehensiveness. Medically required services are those rendered by medical practitioners under the health care insurance plan which, in turn, is the plan established by the law of the province to provide insured health services. Current basic services under the AHCIP are outlined in Appendix XIV of Volume III.

"The health care premium as it is now is a tax that discriminates against low income Albertans.

"It is recommended that more ought to be done with respect to subsidized premiums."
Alberta Teachers Association

However, a number of health care services are not covered under the Canada Health Act, and are not insured either by a government insurance plan or by third-party insurance. Albertans want access through insurance to many services outside those covered by the current government social insurance program.

One approach would be to have the government, or a private sector insurance company with or without the help of government, develop a supplementary health care insurance plan to cover, on a pooled-risk but sound actuarial basis, a much wider range of services from approved providers. The approach could be similar to the vehicle insurance industry — premiums would be based on extent of coverage wanted, extent of risk involved, and number of individuals demanding the coverage. Government could, as it does now with its health care insurance program, choose to subsidize all or part of the premium cost for selected groups of individuals.

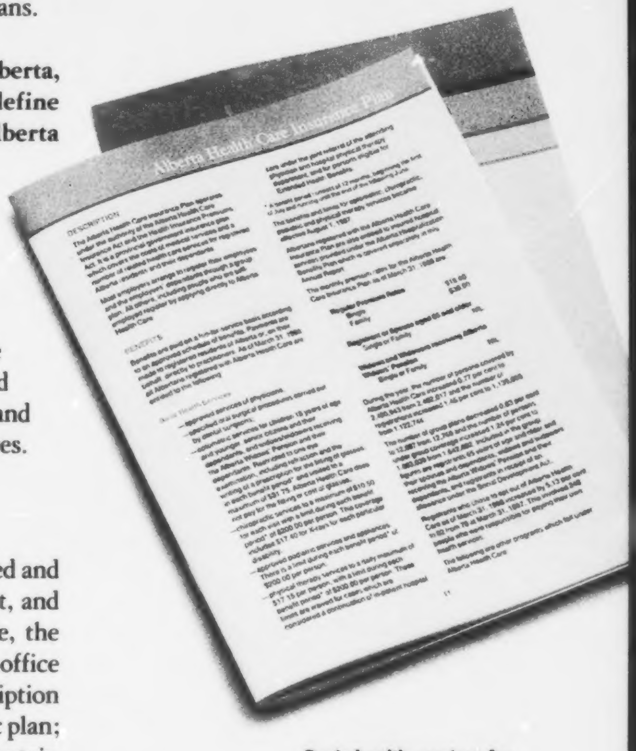
"Currently the Government does not permit co-insurance ...This discourages the utilization of cost-effective treatment regimes not wholly covered by AHC."
Dr. W. Foord
College of Chiropractors
of Alberta

The supplementary insurance program would be demand-driven, and might be successful only if a large number of provider groups join together to offer a broad range of coverage attractive to a large number of Albertans.

8.0 **THEREFORE, WE RECOMMEND that the Government of Alberta, in consultation with health care practitioners and consumers, define what it considers to be basic insured services covered by the Alberta Health Care Insurance Plan;**

8.1 that a supplementary health insurance plan for Albertans who want the option of additional services beyond the basics be established; and

8.2 that the Alberta Health Care Insurance Plan, through either the basic or supplementary plan, expand coverage to include approved alternate care providers within the system to improve the mix and efficiency of services, and to provide a range of less costly services.


Alberta Health Care Insurance Plan

Basic health services for Albertans were listed in the Alberta Hospitals and Medical Care Annual Report 1987-88.

Directions for Implementation

Once basic services have been defined, they should be fully insured and paid for from the public purse as stipulated by the Canada Health Act, and eligible under the Alberta Health Care Insurance Plan. For example, the government might deem certain medical services, such as a variety of office visits to physicians for advice concerning cosmetic problems — a prescription for treatment of baldness, for instance — as not insured under the basic plan; whereas other services provided by non-physician practitioners — certain forms of counselling — could be deemed part of the basic plan.

The introduction of a supplemental insurance program would allow government to insure a wider variety of health services including those provided by medical as well as non-medical practitioners. It also would allow such services to be insured in part or in whole by non-government third-party insurers.

The services included in the basic and supplemental plans must be redefined from time to time and publicly presented by the government of the day. This ensures that the criterion of public accountability is fulfilled regarding the expenditure of public monies for the provision of health services by health practitioners.

The government might encourage and help various health care practitioners to provide a practitioner-sponsored, non-profit supplemental health services insurance plan for Albertans. One interesting approach might mean the re-introduction by a coalition of provider groups of the Medical Services Incorporated (MSI) insurance scheme. That plan was put in place by Alberta physicians as a non-profit plan in the 1940s and was in operation through to the late 1960s. Another recent plan is the "Quikcard" program launched by the non-profit Alberta Dental Service Corporation to provide dental coverage to groups of two to 2,000. A variety of creative approaches, in fact, would be possible — the number would depend upon the choices of consumers.

"It is recommended that if a comprehensive disability insurance program is going to work, the equipment and support services that are needed by a physically disabled person to live independently within the community have to be operational, and should be subsidized."
The Alberta Rehabilitation Council for the Disabled, operating as The Easter Seal Ability Council

"It is recommended that we should look at supporting health service innovations to disadvantaged groups such as certain ethnic groups, urban natives and the poor."
R.D. Hamm

A very good example of the difficulty concerning basic insured versus uninsured services lies in the area of disability insurance for non-working individuals. Disability insurance can be purchased by most fully employed adults, but is not available for technically "unemployed" adults, including homemakers. Nevertheless, this group is equally vulnerable to involvement in an accident. One in five Canadian adults had an accident in 1987, and Statistics Canada estimates that one in eight adults is now disabled to some degree. The probability that an individual will suffer a disability rather than death before age 40 is better than two-to-one. Furthermore, chronic disabling disease can afflict anyone.

The problem is that without third-party disability insurance, a family or individual can be forced into bankruptcy before social insurance programs kick in for home care and community services. This forces families, for financial reasons, to use physicians and institutional services because they are covered by the provincial health program. The necessity for such actions seems inconsistent and unworthy of a society that believes in providing insurance for most catastrophic events. The rationale lies in providing the greatest good to the greatest number.

This type of problem could be corrected by the introduction of a universal disability insurance program supported in whole or in part by government social insurance. On the other hand, direct payment based on established need could go a long way to correcting the problem — with probably no additional costs to the public purse because of the decreased need for institutional beds.

Direct payment

No Albertan bears a serious cost burden because of the costs of diagnosing and treating illness or injury so long as this is provided through our hospital and health insurance plans. The same is not the case for the aftermath of illness or injury. Coping with ongoing health needs, or accessing care outside the current hospital and health insurance plans can create stressful and worrisome situations for victims and their families.

For some of us who have adequate financial resources or are covered by comprehensive disability insurance, this does not normally pose a problem over the short term. There are an increasing number of private insurance companies offering long-term disability insurance as employee benefits, but some plans can be a land mine of exclusionary clauses for the uninitiated, and a high risk venture for insurance companies.

But what about the rest of us? Home care alternatives are available for those select individuals who qualify, are over 65 years of age, or in a designated facility, and have specific medical needs for a limited time. When family resources, volunteer programs, or home care alternatives no longer work, people either have to enter institutions to get the supports and services they need, or seek financial support through social assistance.

> *"Jennifer could get a short-term income for the severely handicapped payments if she and Paul were divorced. Or, if Paul quit his job and went on welfare, since his income is considered too hefty to warrant government help. Or, she could get the full-time care she requires if she gave up and allowed herself to be institutionalized."*
> *Calgary Herald, October 22, 1989*

In order to meet the criteria for social assistance, one must exhaust one's savings, possessions, and investments, and accept dependence on welfare. This financial support is lessened when the individual goes back to work and earns above a certain level of income.

Albertans don't want a system that requires us to go on welfare to receive assistance for ongoing health supports. The Commission was told that it is wrong that one *has* to be poor or unemployed in order to justify public expenditure for such ongoing health needs. A growing number of older Albertans, and people with physical disabilities, also challenge being institutionalized in order to get health supports when they might be better cared for at home.

"It is recommended that in order to reduce the need for institutional care beds, it is imperative a long-term care program in the community be established to ensure Albertans with physical disabilities presently residing in the community, with the help of their families, will be allowed to stay in the community."
The Alberta Rehabilitation Council for the Disabled, operating as The Easter Seal Ability Council

There is a better way. Albertans have been pioneers in the area of direct payment. Through Handicapped Children's Services, our first program of direct payment established in the 1970s, the family negotiates a contract with the government to finance what the family needs to make it possible for their child to live at home. This program deals with direct payment for medically, physically, or mentally handicapped children in Alberta. It is not asset tested. It has allocated funds for more than 4,600 children in the past 15 years, with 75 per cent of families receiving funds directly while third parties handle the remainder.

This natural partnership between the government and family in providing for our children has not been as easily extended to adults. We seem to have been reluctant to take the next step: to recognize that adults with ongoing needs also can negotiate contracts to allow them to live and grow within their communities.

Yet, a number of alternatives currently exist with regard to the concept of a direct payment scheme for persons with ongoing special health needs.

— *The combined use of Assured Income for Severely Handicapped and Social Allowance Programs (AISH/SAL):* since April 1989, has allocated funds to nearly 2,000 Albertans. However, there are restrictions placed on allowable income and assets. Some families are forced into divorce or liquidation of assets so the handicapped member can continue to receive this benefit;

— *Alberta Health: Home Care Post Polio program:* provides funding to nine post polio respiratory quadriplegic patients, since April 1989. The Post Polio program and Handicapped Children's Services — ideal models which should be extended to others with special needs — are set up so that the person can receive services for personal/attendant care, remain employable, and not be forced to live in a designated facility; and

— *Mental Health Approved Home Operation:* has been operational since 1972, and now serves almost 200 clients who suffer chronic mental illness and cannot live independently but do not require institutionalization. Clients receive funds through assured income programs and social assistance and pay room and board and other living expenses; Alberta Health remunerates home operators for the support services they provide. Clients live in stable home/family settings and are involved in constructive activities. Some move on to independent living arrangements, most remain part of the program, but few ever return to institutions; and

— *Workers' Compensation Board:* provides total disability payments to almost 500 persons and additional partial benefits to more than 13,000. These payments are considered income supplements and the person is free to spend the money as required.

Direct payment has not only been an extremely effective method of providing more personalized services to individuals while reducing costs, it also has proved to be powerful in allowing people to assume control and responsibility over their own health care needs. However, the individuals who are currently the pioneers of direct payment live in fear of funding being stopped.

Direct payment requires a dramatic rethinking of current service delivery practices; of the roles of recipients, providers, and government administrators; and of our current view of people with chronic health and disabling conditions. The extension of direct payment approaches could have an impact in a number of ways. It would provide a means for the coordination of government funding of various programs into a single, more easily handled contract. Secondly, direct payment could provide a new funding alternative for community development that would foster a responsive and flexible resource base so that people and their families would have options and choices. People could purchase ongoing services from the volunteer, private, government, or self-help sectors, for example, with respect to home care and long-term care facilities.

Direct payment also could have a profound positive effect on the operation of Home Care's current program by opening the door to options and competition in the community care sector. Rather than tendering individuals to agencies, the individual could be given a voucher or funds directly, and allowed to choose the most appropriate service and provider.

In long-term care facilities, direct payment would extend the current trends toward funding people according to their specific needs. Long-term care operators told the Commission they wanted to become more a part of their communities to respond to local needs. Direct payment would allow them to do so. These operators would receive part of their budget from the Health Authority; the balance coming through meeting the unique needs of those residents who require services that the community has developed.

But there are cautions. People cannot be expected to assume this major responsibility as case managers without information and support. A community care network system is essential to ensure people are not dumped into a situation where they have the money but no way to spend it or no skills to make the best use of their funds.

"Family empowerment should be stressed; and examination of the family's burden, feelings and situation should be made. The family should be taught about the resources in the community, management techniques with the elderly and be provided counselling. Value judgements should be avoided, although community care is most often preferable — each family's case must be examined individually."

The Registered Psychiatric Nurses' Association of Alberta

"Serious consideration must be given to community-based, multidisciplined and easily accessible clinics which serve the health needs of Albertans with greater utilization of both medical and social work services. Without violating universality of access, such services might function under privatized mandates, with incentives for community (consumer or client) group sponsorship."

Faculty of Social Welfare, University of Calgary

How do we ensure that individuals and their families have the resources they need to make the best choices to cope with ongoing and changing needs in a way that provides both security and the opportunity to remain independent, either at home or in institutions? How do we redeploy the resources that will be needed to ensure that patients are not transferred from institutions without support, that families do not become captive to family members who have rising needs, or that institutions are left without adequate resources to serve their patients?

We cannot expect to serve all our needs in institutions, nor can we simply transfer large numbers of people from secure institutional services and expect the community to rally to meet their needs without resources.

9.0 THEREFORE, WE RECOMMEND that the concept of personalized direct payment to people with special need for support be applied to current and potential community-based programs, so as to help reduce barriers and restrictions, while encouraging self-reliance and dignity; and

9.1 that enabling legislation and regulations for such direct payment programs be in place no later than April 1, 1993.

Directions for Implementation

Alberta already has some programs which allocate funds directly to the individual. Unfortunately, there are few initiatives like the Handicapped Children's Services program which have an official, regulatory mandate to provide service dollars to individuals. Short-term solutions must be replaced with long-term, permanent healthy public policies.

Consumers need to be well-informed and prepared to take responsibility for their own health. People in stress can best use information that is practical, uses non-technical language, and is presented by an individual with whom they can identify.

"It is recommended that initial priority be given to the development of particular applications which promise to help build an integrated province-wide health information system, with respect to rural and community hospitals information systems."
Unisys Canada Health Care Services Centre

Health Authorities should establish Standing Committees on Direct Payment to ensure acceptance. Direct payment policy must ensure that public funds are distributed and managed in at least as an effective, efficient and accountable manner as at present. To provide a mechanism for the ongoing review of the direct payment policy, we suggest that these Standing Committees comprise consumers who use direct payment, government officials, administrative representatives of AISH/SAL, home care officials, representatives of Handicapped Children's Services, government and community staff who are familiar with the day-to-day operation of direct payment, and others with specific interest or expertise. The committees would work closely with appropriate provider groups.

The functions of the Standing Committees would include establishing accountability procedures; developing provincial health service brokerage standards; costing methods for direct payment; and providing cost comparisons between previous approaches and direct payment, and between alternatives within the direct payment approach.

As well, courses and programs need to be developed and implemented along the lines of the courses run at the University of Calgary to train health services brokers in providing support for persons and families who need assistance in acquiring funds and services. Mechanisms should be devised to provide these brokers with equitable salaries, rather than a percentage of the direct payment budget for services. Licensing standards could be developed for non-profit brokerage agencies by appropriate government departments, consumers, and Health Authority representatives. Attendant regulations must be in place no later than April 1, 1993.

"It is absolutely essential that any government in Alberta develop a wide range of practical community services making use of skilled trans-disciplinary professionals that can function virtually on their own in a wide range of communities and in relation to a wide range of need."
R.I. Brown

IT CAN WORK FOR ALL OF US

Clearly the Commission supports the aspirations of Albertans to be independent and to have more control over decisions regarding health and health care needs. When we accept personal responsibility for our actions, we also expect that we will be held accountable for the choices we make. This chapter acknowledges the rights of all of us, and recommends certain directions that will increase our power and control through increased knowledge and authority.

Albertans will need something or someone to coordinate the services available to us in our communities. We need a contact to direct us to the appropriate services, practitioners, and facilities. We need an information resource to answer our questions so that we are not lost in the system — not to replace our own personal supports, but to represent a new and challenging way to support community-based services and long-term care. We have chosen to call this the community care network.

The concept of local involvement in health care services centres around the Commission's recommendation for the establishment of local Health Authorities, discussed in detail in the next chapter. Within these Health Authorities, we envision one or more community care networks.

"One possible outcome might be a new kind of community health centre with 'one-stop-shopping' in convenient locations having more flexible hours to better serve the public."
Heart Health Task Committee: Alberta Community Health Directors

We envision a new level of trust and commitment to Albertans as government returns responsibility and accountability to us for disbursing and managing our health care funds. All of us will have access to the type and level of care we need through personal portable funding and direct payment approaches, helped as necessary by community care networks.

We envision hospitals dedicated to those of us whose health needs cannot be met through the community. This means that the sickest people, with the most complex illnesses, would be the ones hospitalized, and only for the shortest length of time possible.

The ideal for the patient within the hospital setting was described to the Commission, and accepted as the epitome of our expectations of the system, and the system's responsiveness to the needs of the patient.

Let the patient speak:

"Ideally, when I am admitted to a hospital, I am taken to a bed and a room where my privacy is respected as much as possible at all times. I have not had to wait weeks or months to have surgery. I am kept informed about what is happening or being planned for me. My health history is on my personal "smart card" and eliminates a lot of questions and tests. Hospital workers talk to one another, share information, and update my card.

"When I require procedures, they will be explained to me and options will be discussed. Whenever possible, if I choose, I will be shown a videotape of the procedure being done so I may ask questions and obtain answers. A family member may accompany me to the operating or procedures room, especially if I am a child. My family may choose to watch what happens on a video monitor and a resource/liaison nurse will be available to explain things, especially if emergencies occur during the procedure.

"When I am well enough, I will be supported in taking care of myself. For instance, I self-administer pain killers (if necessary) and medication from a daily stock at my bedside, just as they would be if I were at home. As soon as possible, after my operation, I will be able to return home with the support of appropriate home care arranged easily and quickly by the hospital through the community care network.

"If I am dying, I have the choice of doing so at home with appropriate support, or in a palliative care centre or hospice, again with those supports I require. My willingness to take risks is respected by my family and my health care providers."

In other words, at all times when we are not healthy, we will be treated with respect and dignity by those serving us from within the health care system.

Given this vision, the Commission acknowledges that both consumers and providers — and the systems within which care is required and care is given — will need assistance to achieve the ideal. The health care system in Alberta is very good…it has the potential to be much better.

Often there is a gap between what we need and what organizations and those close to us can provide. Sometimes how others help us meet our needs is counter-productive. For example, having to move into a nursing home because we can no longer cook and clean may make us more dependent on others than we need to be. Many times, the options presented to us are inappropriate or inflexible. It is all or nothing, even though all we need is a little help.

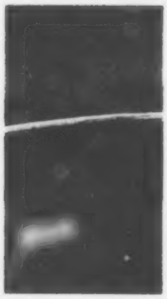
Those working in health organizations can be frustrated as well. The limitations of funding, the processes used to make decisions, or the structure of their organization may limit how they can serve their clients. If we are to meet the challenges of the future, we must foster creativity and commitment among our health care workers by encouraging and rewarding the ingredients of innovation.

Everyone is acting with the best of intentions. We are all doing our best. Yet somehow, the balance in the health system is not quite right...somehow our expectations are not being met as appropriately as we know they could be.

The directions recommended in the next chapter — **The System: Achieving a Balance** — were developed to align our health care services and facilities more directly with our expectations. With commitment from all the major stakeholders, including government, the system can be redesigned and streamlined. The focus *can* be redirected and returned to people — the *real* focus.

CHAPTER THREE

THE SYSTEM: ACHIEVING A BALANCE



BEYOND THE STATUS QUO

The Commission recognizes that it is all very well to suggest that all of us want control and responsibility for our health…we want to be partners with providers in making decisions about our health futures. But, the Commission also recognizes that all of us are most vulnerable when we become some of us…when we are unwell, when something hurts and we don't understand why, when we're frightened about our own humanity, when we're afraid we might die. In truth, when that happens, we don't care who is in control and responsible as long as somebody with competence and compassion is…it doesn't matter who makes the decisions, as long as someone with competence and compassion makes the right ones for us.

"Health service delivery (should be restructured based on) a commitment to balancing provincial education and research emphasis and resource allocations to reflect an equal emphasis on the social, environmental, psychological, spiritual, and physiological aspects of health, injury and illness."
Faculty of Social Welfare, University of Calgary

"The future of our health care system must be a collaborative team approach. Government, health care practitioners, administrators and consumers must find better ways of working together and identifying and solving the health care needs of each unique community."
Staff Nurses Association of Alberta

Fortunately, in Alberta and in the rest of Canada, we have access to the competent care we need when we need it. It doesn't matter if we don't have enough money or up-to-date insurance coverage, the doors to care will not be closed on us. Both the facilities and the providers are there for us...to give us comfort and to make us better, if they can. When we need help, we get it from those who are trained to give it.

Certainly, one of the major challenges facing the Commission was determining the changes that would most appropriately make the health care system even more responsive to the needs and expectations of Albertans in a fiscally responsible manner. It was necessary for us to achieve a balance between the quality and quantity of health care services available to all of us...to set our sights on ideals and translate them into that which is realistic and achievable.

Quality health care goes beyond technical care and capability. It encompasses a more direct, interpersonal partnership between people — both providers and patients; a continuity of care among complementary providers; an integration of skills among practitioners and institutions; and careful, wise management of resources with greater involvement and accountability at the local level. Quality care has people as its focus. Quality care means providing services in a caring and responsive manner.

The Commission acknowledges that change will take time, and requires commitment and cooperation among people involved in all aspects of the health and health care systems. Success will be achieved through appropriate priority setting and progress evaluation; sufficient and predictable funding; joint efforts among public, volunteer and private sectors; and openness and objectivity among stakeholders.

We must recognize that the health care domain is a special and different environment. Health care is big business — it is a major commercial and employment factor within Alberta's economic picture. Our physicians, nurses, and other health care practitioners provide services and institutions house facilities and training programs for which they are all duly compensated. What separates their work from other commercial transactions is that they have a responsibility for the health, well-being and very lives of those of us who pay for their services. The level of trust we have in our health care providers requires that self-interest not be their primary motive — indeed, this is part of their professional ethic — and that they avoid conflict between their interests and our own, and among each other.

The burden of care — whether placed on providers, politicians or bureaucracies — is a heavy one. It encompasses an ethical obligation to provide services in a humane, competent and efficient manner; to ensure equitable access to appropriate facilities and programs; to carry out medical procedures safely within rigorous standards of effectiveness; and to protect and respect the rights and the dignity of the patient. Within this context, health care providers and administrators are expected to manage resources responsibly, economically and efficiently.

Before elaborating on the directions that the Commission feels will lead to our vision of balance between quality care and quantity of health care services, we think it appropriate to present some detail on the system. *Albertans must understand the magnitude of the health care system* — the number of facilities and providers, the costs of operating the system, the sources of funding, and some of the difficulties inherent in such a complex system.

"It is recommended that the provincial government specifically encourage health care institutions to adopt practices which will enhance an ethical approach to the allocation of resources, such as information sharing and two way communication among boards, management, and professional employees."
Grey Nuns of Alberta

"I suggest that the Government should launch a long term public relations program aimed at informing Albertans of the total cost and breakdown of medicare so that they may make an intelligent decision when called upon to do so."
Ralph N. McManus

"Nowhere else in Europe or the U.S.A. have I seen such a consistently high quality of hospital facilities...some people have stated that all these hospitals were 'politically built'. This is at best a mischievous and/or erroneous assumption. To have good facilities is a blessing whether in a large or small community... The fact is the facilities are there, they are good, they should be used to the best advantage."
Dr. Patrick Crowley

Good, better, best

The Canadian health care system is considered among the best in the world. Indeed, in a 1989 three-country comparison study conducted by the United States, the satisfaction level with the system among Canadians — 56 per cent believe it "works pretty well" — is considerably higher than in either the United States or Great Britain — reported at 10 per cent and 27 per cent, respectively. Canadians also expressed higher satisfaction with hospitalization and physician visits in the previous 12 months — 71 per cent and 73 per cent were very satisfied, compared to 57 per cent and 54 per cent among Americans, and 67 per cent and 63 per cent among Britons.

The Public's Overall View of Health Care Systems

	U.S.	Canada	U.K.
On the whole the health care system works pretty well, and only minor changes are necessary to make it better	10%	56%	27%
There are some good things in our health care system, but fundamental changes are needed to make it work better	60	38	52
Our health care system has so much wrong with it that we need to completely rebuild it	29	5	17
Not sure	1	1	4

Satisfaction With Medical Care

Hospitalization*	U.S.	Canada	U.K.
Very satisfied	57%	71%	67%
Somewhat satisfied	28	18	22
Somewhat dissatisfied	7	5	8
Very dissatisfied	8	5	2
Not sure	0	1	1
Visit to physician*			
Very satisfied	54%	73%	63%
Somewhat satisfied	32	21	26
Somewhat dissatisfied	7	4	7
Very dissatisfied	6	2	3
Not sure	0	0	0

*Asked only of those who reported hospitalization or visit to physician in the past twelve months.

Source: Harvard School of Public Health — Louis Harris and Associates. Spring, 1988 Poll for the Baxter Foundation

A recent public opinion poll conducted in Alberta supports these findings, and shows 80 per cent of Albertans rate the health care system as excellent or good.

While our facilities of acute care are exceptional, national and provincial health promotion and illness/injury prevention programs are highly-regarded and gaining more attention, but considered average among developed countries. Promotion and prevention programs are achieving more prominent status in most jurisdictions — the thrust being toward healthier lifestyles and individual responsibility — but, realistically, funding for treatment and services will always take precedence. Alberta spends as much or more than any other province on health promotion and illness/injury prevention, and we receive remarkably fine services from our community and public health programs.

The Commission acknowledges that, by and large, there has been a strong commitment by government and society to put in place programs and systems helpful to and supportive of Albertans. Our attitude over the decades toward social justice as it relates to the ill has been exemplary. Almost since its inauguration as a province, Alberta has been governed by political parties dedicated to free enterprise, who have managed to balance their economic pursuit with a sense of obligation and genuine concern for taking care of and supporting those who, for a variety of reasons, could not do so for themselves.

In spite of the overall excellence of our system to care for the sick which is the envy of many throughout the world, there is an appearance of the system having grown like 'Topsy' — institutions of care dot the province, having been built out of real and perceived needs; and programs having been added to programs, often more in a reactive fashion than in a well-planned, forward-thinking manner. We accept that facilities, services and programs exist. Ways must be sought to increase effectiveness, relevance and coordination.

Matters of health policy are addressed by a wide variety of commissions, committees, task forces, and councils. Some function on an ongoing basis; others take on specific tasks for a term. Currently, there are a number of boards and councils advisory to the Minister of Alberta Health on specific aspects. These include the Public Health Advisory and Appeal Board, the Provincial Mental Health Advisory Council, the Occupational Health and Safety Council, the Provincial Advisory Committee on Suicide Prevention, the Alberta Health Facilities Review Committee, and the Advisory Committee on the Utilization of Medical Services which has recently reported. There also are special committees and councils advising the government, including the Premier's Council on the Status of Persons with Disabilities and this Commission. In addition, numerous interdepartmental, and intergovernmental committees and task forces exist, or are established from time to time to assess and coordinate activities.

"Changes in how we manage our work and social activities and the environment in which we work may be significantly greater in the improvement of our health than direct medical contribution or intervention."
Lutheran Voluntary Health Care Agencies

"There is a need for leadership in society, in government and in the medical profession in planning health care policies. Unfortunately, nobody seems able, in isolation, to meet the challenge."
Dr. M. Watanabe

"It is recommended that more statistical data on a provincial wide basis is required to assist in long-range planning of an efficient medicare service for Albertans."
Alberta Association of Municipal Districts and Counties

"There is a lack of coordinated planning between bodies responsible for the health service continuum due to problems associated with split jurisdictions."
The City of Edmonton

Treatment and care facilities

"There is resistance to change, stemming primarily from the hospital establishment who fear loss of jobs and status, but also from the general public, who do not understand how these changes will improve their health care and are worried that this is yet another cutback."
Calgary Chamber of Commerce

The system, as it currently exists, is highly centralized and remarkably decentralized at the same time. As of March 1988, Alberta had 125 active treatment hospitals, 46 auxiliary hospitals, two mental health hospitals, and 91 nursing homes — most with independent boards. Included are two federal general hospitals, located at Cardston Blood Indian Reserve and Medley Canadian Forces Base at Cold Lake. A map indicating locations of all hospitals is included in Appendix XVI in Volume III.

There are six mental health regions which operate more than 50 mental health clinics throughout the province, with Regional Mental Health Councils advising the provincial Mental Health Advisory Council. In the area of public health, there are 27 autonomous health units, each governed by a board. Currently, there are 128 Family and Community Support Services (FCSS) boards which facilitate coordination and consultation of a variety of locally identified promotion and prevention programs to more than 80 per cent of Albertans.

Bed Capacity	**Number of hospitals**
1-24 beds:	14
25-49 beds:	58
50-99 beds:	30
100-299 beds:	11
300 and more beds:	12

According to the last available Alberta Health annual report (1987-88), those 125 hospitals operate 13,125 adult and child beds (including 879 long-term care beds) providing Albertans with one of the highest ratios of beds per 1,000 population in Canada. The 46 auxiliary hospitals were approved to accommodate 4,287 beds; the two mental health hospitals, 1,072 beds; and the 91 nursing homes, 7,914 beds. Within the acute care public general hospital system in Alberta, hospitals range in size from nine acute care beds and two bassinets in Cereal in southeastern Alberta, population less than 300, to 1,040 acute care beds and 100 bassinets at the University of Alberta Hospitals in Edmonton, population more than half a million and rising.

Hospitals have different government classifications according to whether they provide all or a mix of services:

— *Primary/general care hospitals* include most of our rural hospitals which provide routine obstetrics, medicine, some general surgery and emergency care, for example, but do not require specialized equipment or the skills of specialists;
— *Secondary/general and specialty care hospitals* include regional and most city hospitals which handle the majority of medical problems and accept referrals from general community-based hospitals in such areas as orthopedics, medicine, most general surgery, urology, obstetrics, ear/nose/throat surgery, radiology, pathology, pediatrics, and ophthalmology; and

— *Tertiary/specialized active care hospitals* include major urban medical and referral centres like the University of Alberta Hospitals and the Glenrose Rehabilitation Hospital in Edmonton, and the Foothills Provincial General Hospital and the Alberta Children's Hospital in Calgary, plus the facilities of the Alberta Cancer Board in Edmonton and Calgary. They often are associated with high technology, research and innovative procedures, teaching and training, specialized care such as cancer treatment, and sub-specialty pediatric care, to name a few of the services provided.

The providers

The health care field is a large employer, both nationally and provincially. Nursing, in fact, is the largest profession in Canada. In Alberta, it is safe to say that approximately 55,000 people are registered and practising in the health care professions. Equally as many are employed to provide support services to health care institutions and professional establishments. The Alberta Health and Social Services Disciplines Committee prepares an annual summary of health and social service manpower based on two criteria — only occupations with professional legislation and/or formal training programs in Alberta or by agreement are included. In 1987, 53,784 people were active in 35 health professions, 21 professions were regulated by legislation, and 93 health disciplines training programs were offered.

While manpower shortages exist in some health and health care fields and there are surpluses in others, Alberta's supply of providers, by and large, is as good or better than most other provinces. The majority of our care professionals are educated in more than 90 health and social service programs at the province's close to 30 universities, community colleges and technical institutes, which also offer extensive continuing education courses. In some specialty areas, inter-provincial agreements exist to accommodate a minimum number of students in those programs.

"The greatest problem facing our system at present is the lack of a cohesive plan for the distribution of health care services. It is essential that this issue be addressed vigorously if we are to have reasoned utilization of resources for the future.

It is recommended that it will be necessary to develop a comprehensive regional plan which will designate institutions as community hospitals, regional referral centres and tertiary referral institutions. Central to this designation will be associated different levels of funding."

E.R. Smith

"Under-utilization of nurses and other disciplines is a short fall in the current health care system. Doctors, dentists and chiropractors control access to our health care services."

Alberta Association of Registered Nurses

Health Manpower in Alberta, 1987

	Number of Registered/ Practising Personnel	Personnel to Population Ratio	Regulated by Legislation	Number of Training Programs	Number of Graduates
Audiologists and Speech Pathologists	346	1:6,879		2	30
Biomedical Engineers	17	1:140,012		3	2
Chiropractors	312	1:7,629	X	–	–
Combined Laboratory and X-Ray Technicians	311	1:7,653		1	15
Community Health Representatives	40	1:59,505		1	15
Dental Assistants	2,032	1:1,171	X	3	153
Dental Hygienists	645	1:3,690	X	1	39
Dental Technicians	177	1:13,447	X	1	15
Dentists	1,276	1:1,865	X	1	42
Denturists	201	1:11,842	X	1	14
Dietary Technicians	261	1:9,120		2	45
Dietitians/Nutritionists	359	1:6,630	X	3	36
Emergency Medical Technicians	1,366	1:1,742	X	4	352
Health Record Administrators	149	1:15,974		1	12
Health Record Technicians	293	1:8,124		1	16
Medical Laboratory Technologists	2,294	1:1,038		3	130
Medical Radiation Technologists	1,074	1:2,216	X	4	74
Occupational Hygiene Technologists	113	1:21,064		1	3
Occupational Therapists	348	1:6,840		2	47
Ophthalmic Dispensers	359	1:6,630	X	2	43
Optometrists	212	1:11,227	X	–	–
Pharmacists	1,980	1:1,202	X	1	77
Pharmacy Assistants	465	1:5,119		1	38
Physical Therapists	1,135	1:2,097	X	2	49
Physicians	4,005	1:594	X	2	187
Podiatrists	21	1:3,343	X	–	–
Prosthetists and Orthotists	34	1:70,006		–	–
Psychiatric Nurses	1,018	1:2,338	X	2	51
Psychologists	1,121	1:2,123	X	10	126
Public Health Inspectors	126	1:18,890	X	–	–
Recreational Therapists	262	1:9,085		1	24
Registered Nurses	22,034	1:108	X	24	1,207
Registered Nursing Assistants	7,414	1:321	X	3	265
Rehabilitation Practitioners	1,548	1:1,538		8	147
Respiratory Therapists	457	1:5,208	X	2	51
Subtotal	**53,805**			**93**	**3305**
Child Care Workers	1,428	1:1,667		3	71
Social Workers	2,443	1:974	X	6	380
Total	**57,676**			**102**	**3756**

Source: *Health and Social Service Manpower in Alberta, 1987*, Alberta Health and Social Services Disciplines Committee

The department

Under the overall authority of Alberta Health, the health care system operates within the context of the *Canada Health Act* in accordance with national standards. The system is:

- — universal and accessible: all Albertans have health care coverage and equal access to services;
- — comprehensive: a wide range of services are insured;
- — portable: coverage is transferrable from province to province; and
- — publicly administered: the program operates on a non-profit basis.

Additionally, the provincial government also plays a major role in funding and coordinating health care delivery at the central level under the authority of a number of provincial acts, statutes and regulations, some of which are listed in Appendix XV of Volume III. Health professions, for the most part, are regulated by provincial legislation and must meet provincial standards. Albertans, therefore, have access to a wide range of quality health services across the province.

In 1988, the department was reorganized from Hospitals and Medical Care and Community and Occupational Health to become Alberta Health. Its major responsibilities now include planning and budgeting for health care delivery systems — hospitals, long-term care facilities, home care,and ambulance and emergency health services; health promotion and illness/injury prevention programs; community health including public and mental health services and clinics; the administration of the Alberta Health Care Insurance Program; and research, policy development and implementation, and systems technology. While planning and approval for new hospitals and renovations still occur with Alberta Health, a great deal of responsibility and funding for capital construction projects has been transferred to Alberta Public Works, Supply and Services.

The new department has drafted mission and role statements closely aligned with those issued by the Commission for public reaction. The department sees itself as having "a unique role in the health system — in addition to delivering programs and services, it has a role to establish standards, fund other groups to deliver services and ensure stewardship of resources. It plays a key role in facilitating coordination and collaboration...and to evaluate effectiveness of health programs and policies."

It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

Canada Health Act (Bill C-3 as passed by the House of Commons, April 9, 1984)

"Health care legislation has been heavily influenced by the lobbying efforts of powerful groups such as hospital organizations, physician organizations and medical industrial interests. There seems to be considerably less response to input from the community level and organizations of health care practitioners other than physicians, and groups concerned with a specific health care issue."

Boyle-McCauley Health Centre

Funding forces form

Despite provincial responsibility for health care services, the federal government has been involved in various cost-sharing mechanisms to balance fiscal resources and provide an equitable level of provincial public services without excessive taxes in any given region. Origins of federal contributions remained institutionally-based from the 1950s until the more recent formula for Established Programs Financing (EPF) was introduced in the 1980s. The original funding structure created an incentive for provinces to build and expand health service facilities — the more hospitals, the more beds, the more funds. As well, bricks and mortar became an attractive approach for politicians within their constituencies — it is much easier to put a commemorative plaque on a building than on a program. As is the case in a number of cost-shared programs, the provinces made many capital commitments based on federal involvement, and continue to bear the burden of operating costs after the federal government has pulled out of the arrangement.

Provincially, funding decisions are made on past budget performance with adjustments made for changing needs and inflation. New program funding is handled as a separate budget item. Alberta Health is currently exploring options to move toward funding based on the complexity of the treatment provided to patients and the number of patients treated.

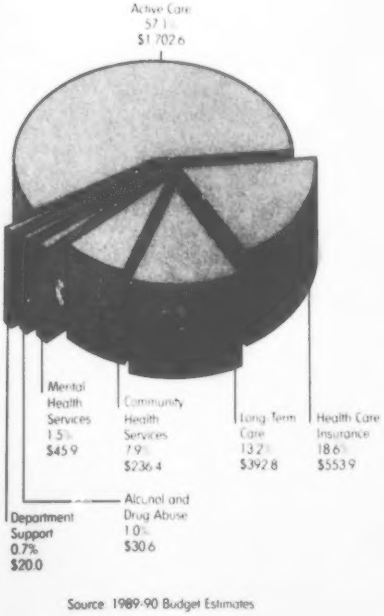
The Advisory Committee on the Utilization of Medical Services - 1989, has commented extensively on barriers to cost-effective health care in Alberta from the perspective of the institutional funding system, and the Commission is generally supportive of their recommendations (see Appendix IX, Volume III).

The budget estimate for Alberta Health for 1989/90 is nearly $3.0 billion and of this, $1.7 billion — 57 per cent — is for financial assistance to active care hospital-based services. Within the budget for financial assistance for active care, $859 million (50 per cent) goes to major urban and referral centres, $184 million (10 per cent) goes to other referral centres, and $207 million (12 per cent) goes to specialized active care hospitals. Only $324 million (14 per cent) goes to community-based hospitals with less than 100 beds. Separate from these figures are capital allocations for new hospitals, which have decreased continuously from a high of $255 million in actual expenditures in 1983/84 to $149 million in 1987/88. If the decline in capital construction does not continue well into the 1990s, then the capacity of government to fund new — and even existing — programs will be seriously constrained.

"It is recommended that there is a need for a rational reorganization of Alberta's antiquated system of awkwardly overlapping local health service districts and our provincial departmental structures which have developed over decades."
Provincial Senior Citizens Advisory Council

"For far too long there has been a brick and mortar mentality regarding Health care in Alberta. Hospitals were built with what seemed to be little regard for the real health care needs of Albertans."
Alberta Society of the Friends of Medicare

Alberta Health
1989-90 Budget Estimates
(\$Millions)



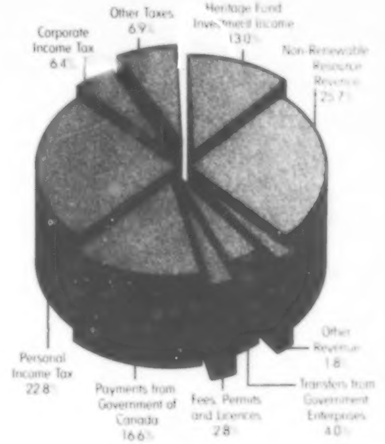
Source: 1989-90 Budget Estimates

Obviously, we spend substantial dollars on our hospital system, with the bulk of the funding — 72 per cent — going to our larger, urban and referral facilities. But regardless of the amounts we spend, one of the needs in the system is to ensure that it is designed to, and does, serve Albertans in a locally responsive and caring way.

The funding of health care in Canada is largely through social insurance programs. And although our health care expenditure as a percentage of our gross domestic product when compared to other developed countries is not excessive, health care is still expensive. One reason for this could be analogous to the "lunch theory" presented by Donald Savoie in his book, *The Politics of Public Spending in Canada.* He argues that increased government spending and our inability to cut back can be compared to 11 people (the 10 provinces and the federal government) meeting for the first time over lunch. A decision must be made as to whether they should share one cheque or have 11 separate ones. The theory is that if they decide on one shared cheque, they will all choose the more costly items, which they would not have done if each were paying individually. This, he argues, is why public spending and federal and provincial deficits are so high. Why not? If Alberta takes less, some other province will surely take more, while we still share in the overall cost.

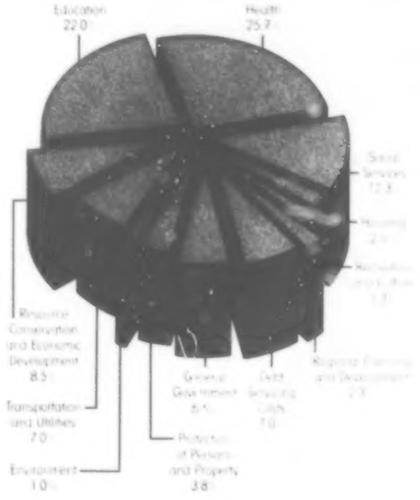
The Government of Alberta budgetary expenditure estimate for 1989/90 is $11.7 billion. Allocations for social programs are substantial — $3.0 billion (25.7 per cent) to health, $2.6 billion (22 per cent) to education, $1.4 billion (12.3 per cent) to social services, and $0.12 billion (1.0 per cent) to environment. It is agreed that provincially-supported health care programs in Alberta include the most generous benefits in Canada. About 73 per cent of the total funding comes from the provincial government, 20 per cent from the federal government as cash transfers, and about 7.0 per cent from premiums and interest.

Alberta Budgetary Revenue
By Major Source, 1989-90 Estimate
Total Budgetary Revenue = $10,181 million



Source: Alberta Budget Estimates

Alberta Budgetary Expenditure
By Major Function, 1989-90 Estimate
Total Budgetary Expenditure = $11,674 million



Source: Alberta Budget Estimates

"Hospitals should be financed on the basis of programs and performance rather than process and resource measurements. Hospital budgets should be program (output) based rather than our current departmental (input) basis."
Walter Braul, Q.C.

"A mechanism is needed where funding is awarded on the basis of fact and not opinion. All new health programs must be subjected to objective evaluation criteria. Any agency which is given approval for program or service implementation must undergo an evaluation program."
The Alberta Chapters of the Canadian College of Health Service Executives

Of a total health expenditure of approximately $1,900 per person in Alberta in 1987, $1,600 was for personal health of which about $1,350 (85 per cent) came from the public purse.

Total Individual Health Expenditures by Category
Dollars per person — Alberta 1975-87

	1975	1980	1987(a)
Total expense	567.87	1003.56	1898.55
Personal health care	497.48	761.53	1589.07
Institutional and related services	313.19	453.73	916.79
Hospitals	245.75	350.87	759.02
Other institutions	65.15	99.88	139.68
Home care	.98	.18	11.01
Ambulances	1.31	2.81	7.08
Professional services	126.05	211.41	439.06
Physicians	85.85	140.49	278.07
Dentists	32.22	55.77	128.05
Other professionals	7.97	15.15	32.94
Drugs and appliances	58.24	96.39	233.22
Prescribed drugs	25.01	39.65	91.03
Non-prescribed drugs	22.79	36.79	90.92
Eyeglasses	8.45	12.61	27.07
Hearing aids	.87	1.44	2.00
Other appliances and prostheses	1.12	5.91	22.19
Other health expenses	70.39	242.03	309.48
Prepayment administration	4.92	15.95	27.76
Public health	28.57	56.16	140.29
Capital expenditure	26.86	139.86	109.95
Health research	5.09	10.87	15.12
Miscellaneous health costs	4.90	13.19	16.35

(a) Provisional

Source: Health & Welfare, Canada

Although health care costs continue to increase, they are not out of line with those anticipated by Emmett Hall in the early 1960s. The real Canadian problem lies with having to service our national debt — clearly an erosion of our power and capacity to provide for various social programs. While true at the national level, this is becoming increasingly so at the provincial level as well.

A major problem regarding funding is that, while total health costs are going up, albeit less rapidly in recent years, the federal contribution through Established Programs Financing (EPF) for health is decreasing (see Appendix X, Established Programs Financing, Volume III). EPF provides conditional federal contributions toward the costs of health and post-secondary education — provincial responsibilities under the *Constitution Act, 1982* — through a formula of cash transfers and tax credits.

> **"Strategies for cost containment include decentralization of programs/services with emphasis on less costly community-based services such as outreach clinics and home care."**
> Alberta Cancer Board

EPF Transfers to Alberta — Cash and Tax
1977/78 to 1990/94

Year	$Million	%change	Notes
1977/78	550		Block funding started
1978/79	652	18.5	
1979/80	789	21.0	
1980/81	944	19.6	
1981/82	1117	18.3	
1982/83	1167	4.5	Revenue guarantee eliminated plus all transfers on equal/capita basis
1983/84	1280	9.7	6% + 5% ceiling on post secondary transfer for 83/84 and 84/85; revenue lost because base lowered
1984/85	1364	6.6	
1985/86	1463	7.3	GNP - 2 Introduced
1986/87	1566	7.0	
1987/88	1644	5.0	
1988/89	1731	5.3	
1989/90	1839	6.2	
1990/91	1942	5.6*	Formula to change from GNP-2 to GNP-3
1991/92	2023	4.2	
1992/93	2094	3.5	
1993/94	2162	3.2	

*Based on measures in April 1989 budget which changes the formula beginning in 1990/91.

1989/90 figures

Source: Federal Finance

"It is recommended that the Premier's Commission take a firm stand when dealing with the federal government, in order to bring some sense of individual responsibility back into social programs."
W. Youngs

"If the Provincial Government wishes to maintain a commitment to the Medicare principles of universality and first-dollar coverage, then it will have to convince the Federal Government to renegotiate Established Programs Financing and to share more equitably in the cost of ensuring quality health care.

It is recommended that the Government of Alberta convince the Government of Canada to fulfill its responsibility for funding health care by restoring its contributions to a level necessary to fulfill its commitment to the Medicare scheme."
Alberta Medical Association

The federal contribution through the EPF is projected to decrease even more under the latest formula introduced by the federal government, to the point where, in fiscal years 1990/91 and 1991/92, Alberta's revenue from EPF will be $60 million less than in previous years. And, there is speculation that cash and tax credit transfers, previously earmarked as EPF funds, will become an even more obvious source for attacking the federal deficit than is now the case. This is a rather strange twist on "he who pays the piper calls the tune" — without paying, the federal government continues calling, much to the aggravation of the provinces who have to increasingly "pay for the tune".

Concerning revenues and expenditures, federally and provincially, as they relate to health care, some observations are important. Federally, in 1987/88, $29.0 billion was allocated to National Health and Welfare, of which $6.6 billion was transferred to provincial health services through EPF arrangements. The majority of the balance went to welfare ($4.4 billion), family allowance ($2.6 billion), old age security ($10.2 billion), and guaranteed income supplement ($3.6 billion). Thus, of total federal expenditures of $115 billion, only 5.7 per cent — that $6.6 billion in transfers — went directly to health services provided by the provinces. Coincidentally, that year the same amount budgeted for health and citizen assistance programs — $29 billion — was also expended in interest on the federal public debt.

The 1989/90 estimate for Alberta Health is $2.982 billion. Provincial revenue from personal income tax is estimated to be $2.326 billion and from corporate income tax, $0.650 billion, for a total of $2.976 billion. Thus, if all revenues from personal and corporate tax in Alberta went to health, we would incur a $6 million deficit. *Every dollar provided by Albertans through taxes, personal and corporate, would not be enough to cover our annual health budget.*

Federal and Provincial Health Budgets as a Percentage of Total Budgets 1979-1988
(annualized to calendar years)

	Budget for Health (Millions of Dollars)		Total Budget (Millions of Dollars)		Health Budget as a % of Total Budget (Percentage)	
Year	**Federal[1]**	**Provincial[2]**	**Federal[3]**	**Provincial[4]**	**Federal**	**Provincial**
1979	$3,699	$855	$49,556	$3,634	7.46%	23.52%
1980	$3,934	$1,058	$58,211	$4,192	6.76%	25.23%
1981	$4,193	$1,354	$64,131	$5,133	6.54%	26.37%
1982	$4,111	$1,776	$73,066	$6,673	5.63%	26.61%
1983	$5,188	$2,005	$82,701	$7,530	6.27%	26.63%
1984	$6,139	$2,092	$92,846	$7,580	6.61%	27.60%
1985	$6,372	$2,265	$97,881	$8,423	6.51%	26.89%
1986	$6,562	$2,493	$101,372	$9,057	6.47%	27.52%
1987	$6,574	$2,502	$108,446	$9,143	6.06%	27.37%
1988	$6,913	$2,653	$113,352	$9,528	6.10%	27.85%

Sources:

1. Public Accounts of Canada. Figures show transfers under the Federal-Provincial Arrangements and Established Programs Financing Act, 1977. Figures are in current dollars and represent operating figures only.
2. Alberta Health. Figures are operating estimates and are in current dollars.
3. Public Accounts of Canada. Current dollars represented.
4. Alberta Treasury. Operating estimates are represented and in current dollars.

In terms of paying for health care in Alberta, one way of expressing it is to develop an estimate of how much a family of four with one income earner has contributed in taxes and premiums toward health care.

"Government funding of various health services has heavily influenced utilization and patterns of care, sometimes in ways that are extremely inefficient.

The government should look for ways to encourage innovation from the professional providers, the patient/consumers, and the government alike."
Alberta Association of Optometrists

"It is recommended that there be some consideration for payment for lifestyle induced disease treatment as well as tax breaks for healthy lifestyle choices."
Wetoka Health Unit Board

Using this approach, in 1980, a family with an income of $35,000 contributed $536 for government-funded health care programs, while one with an income of $50,000 paid $914. Let us assume that both wage earners received salary increases during the next eight years. The first family now earns $50,000 and pays $1,932 for health care. The second family income is now $75,000 and their health care contribution is $3,385.

This is based on the assumption that the percentage of expenditure in the federal and provincial budgets going to health is the same percentage paid as a proportion of total federal and provincial taxes paid. For example, in 1988, for every $100 paid in income tax, the amount paid for health care as a proportion of provincial tax was $27.85; of federal tax, $6.10. As our incomes increase, the proportion paid toward health care remains the same, but the total dollar contribution increases.

Estimated Payments for Health Care by Family Income Groups in Alberta 1979-1988

Annual Family Income Levels	1980	1981	1982	1983	1984	1985	1986	1987	1988
$15,000	$208	$228	$228	$336	$336	$341	$347	$432	$432
$25,000	$297	$360	$397	$526	$558	$568	$608	$781	$756
$35,000	$536	$631	$669	$818	$893	$902	$957	$1,184	$1,162
$50,000	$914	$1,077	$1,142	$1,337	$1,478	$1,496	$1,594	$1,905	$1,932
$75,000	$1,738	$2,036	$2,080	$2,361	$2,696	$2,701	$2,888	$3,591	$3,385
$100,000	$2,665	$3,111	$3,151	$3,533	$4,040	$4,047	$4,367	$5,106	$4,889
$125,000	$3,628	$4,224	$4,253	$4,739	$5,436	$5,452	$5,899	$6,832	$6,392

NOTE: Assumes a family of four with one employment income earner and two children. Data and estimates are in current $.

Data Sources: Public Accounts of Canada, Public Accounts of Alberta, Alberta Health Care Insurance Plan.

Estimated Health Care payments based on annual Alberta health care premiums plus estimated amount of health expenditure based on portions of federal and provincial tax paid.

This confirms that health care in Alberta is not free, and that it is paid for, overall, according to the ability to pay. As Canadians, and Albertans, more and more is being deducted from our income, most of which goes to taxes. For instance, from 1961 to 1987, the average deduction as a percentage of personal income expressed on a per capita basis rose from 9.2 to 22.1 per cent in Alberta and 10.4 to 21.5 per cent for Canada. Meanwhile, over the period 1971 to 1987, the Alberta government contributions, including federal transfer payments, to per capita health care expenditures, in current dollars, went from $206.30 to $1,437.70.

Some interesting approaches have been suggested in an attempt to raise more revenues to cover the increased cost of health and other social programs. Excise taxes on cigarettes and alcohol are usually increased once or twice during the fiscal year and have become major sources of revenue. However, some jurisdictions have begun to look at people who through negligence contribute to rising health care costs. For instance, the Quebec government plans to obtain reimbursement for part of the costs of care required for drivers convicted of impaired driving following accidents for which they are responsible. Another approach would be to charge additional dollars for those seeking to obtain driver's license renewals after conviction for impaired driving; suggestions range from a flat $1000 to a maximum of 10 per cent of one's previous year's gross, not taxable, income.

One defence for maintaining the premium system for health care insurance is the notion that if health care is a right, then to pay is an obligation. The position taken is that all of us should contribute to health care costs according to our ability to pay — before deductions to our taxable income, not after.

"We need some idea of what as a society we are willing to pay in the form of taxes. We also need some clear idea from government about their priorities for funding allocation, and we need clearly stated funding policies.

It is recommended that there be some agreement as to what portion of the tax revenue base will be devoted to health care."

E.G. Heidemann

Alberta Government Contributions to Per Capita Health Care Expenditures
1970-71 to 1986-87

Year	Alberta $
1986-87	1,437.70
1985-86	1,320.80
1984-85	1,227.50
1983-84	1,230.80
1982-83	1,130.40
1981-82	900.70
1980-81	747.80
1979-80	607.10
1978-79	530.10
1977-78	475.30
1976-77	509.40
1975-76	408.90
1974-75	317.00
1973-74	264.80
1972-73	233.60
1971-72	224.30
1970-71	206.30

Source: Statistics Canada Catalogues 68-207 and 68-211

"Because all the costs associated with health care in Alberta have traditionally been borne by government, many individuals are reluctant to remove the government obligation in this regard.

It is recommended that every effort should be made to re-assure people that their tax dollars will continue to cover basic health care costs."
M. Fyfe

PLANNING AND POWER: SERIOUS REDISTRIBUTION

The Commission recognizes that — just as physicians cannot be all things to all people — Alberta Health cannot be all things to all systems. There is a very real need to reassess the priorities of the department, to determine those things which it does best or could do better given the time and direction.

Government as a whole — and certainly Alberta Health in recent months — has shown its commitment toward improving the health system and preparing for the future. A number of committees recently analyzed the system from various perspectives: the *New Vision for Long-term Care — Meeting the Need;* the Report of the Advisory Committee on the Utilization of Medical Services — *An Agenda for Action;* and *New Dimensions in Emergency Health Services: An Alberta Solution.* The Commission carefully reviewed these reports and supports, in general, the majority of recommendations, while recognizing that these reports are directed primarily at current problems and provide, mainly, current solutions. Additionally, excellent efforts have been put into special task forces and committees — resulting in such discussion papers as one on reproductive health, *In Trouble...A Way Out;* another on children's injuries; plus *Promoting Heart Health in Canada.*

Some of the suggestions and solutions will be suitable into the Twenty-first Century — some may not be. Nonetheless, all point to improvement and change.

"We have to decide how important health care is to us."
E. Maroes

Current priorities, goals and objectives — embodied in legislation, throne speeches, ministerial speeches, reports on government policies and directives — generally have not been consolidated and communicated widely in an easily understood manner. The Commission views recent actions as extremely positive and indicative of the government's willingness to articulate its position, particularly in what we deem to be healthy public policy areas — release of *Toward the Twenty-first Century,* new principles and policies for public reaction to form the framework for new environmental protection legislation; circulation by the Minister of Health of the department's mission and role statement, and principles of operation; and publication in 1988 of *Caring and Responsibility: A Statement of Social Policy for Alberta.*

Openness regarding government policy formulation in areas so directly affecting Albertans — as individuals and as a society — should result in more relevant legislation. Inviting public participation and reaction before casting decisions in stone provides necessary balance. Additionally, major stakeholders — public, private and volunteer sectors, consumers and providers — have to be brought together in a cooperative and coordinated effort to affect the synergy that so often is lacking.

Specifically within the health care domain, the Commission sees a system that will be managed within a framework of healthy public policy. Its policies will create and encourage health, be mutually supportive, and recognize the broad definition of health as enunciated in the Commission's Mission Statement and the World Health Organization's definition of health. The management of the system will be based on reliable, current and comprehensive data, and these data will relate to the broad definition of health, not simply health care.

By necessity, mechanisms must be put in place that will ensure responsiveness to changes in health needs, resources and technology; that will foster innovation and have a futuristic orientation. Directions, priorities, and long-term planning will be collaborative, coordinated and visionary.

Importantly, the Commission sees a return to the local level with respect to planning, delivery, and accountability for health and health care services. Within the context of autonomous areas of health delivery, more relevant programs can be coordinated and more appropriate utilization of facilities can occur. At the same time, we are committed to maintaining the centralized approach with respect to overall standards, monitoring, evaluation, and coordination.

Alberta will work closely with other levels of government within the province, and with other provincial governments and the federal government, as well as internationally, to develop consistent and meaningful public health policy. Long-range strategic planning and short-term implementation — rational, and based on objective criteria, widely publicized and understood — should become the norm. As a result, health care resources will be utilized and distributed more efficiently, effectively, and economically throughout the province. Health promotion and illness/injury prevention will reach audiences feared to be lost causes, and healthy lifestyles and behaviours will become a matter of pride and achievement.

"It is recommended that the public and the professions work together to reach the common goal of a better health care system for less money."
A. Meldrum

"It is recommended that there be more resources allocated to WHO (World Health Organization) Model of Health (i.e. wellness and prevention of illness), rather than the Medical model (i.e. absence of disease), where the focus is on fixing bodies after they have broken down."
M.J. Davis

"Public attitudes and expectations are changing. Our communities are more knowledgeable, sophisticated and interested in taking control of their health."
Leduc-Strathcona Health Unit

"It is recommended that, with regard to health care, the needs of the public must be identified separately from the expectations of the public: once needs are determined, money should be put toward these identified areas before it is put toward the public's expectations."
L. Temple

"It is recommended that methods be developed to monitor the province's achievement of its mission, goals and objectives, using available data and techniques such as the regular conduct of health status surveys."

Foothills Provincial General Hospital

"Nearly every health care facility has a goal of providing 'quality' care. Unfortunately many people do not understand the true nature of 'quality' and it is often mistaken for care of a sophisticated or complex nature. Quality refers to compliance with requirements or standards and nothing more. You can have a 'quality' Volkswagen and a 'quality' Cadillac but they are very different cars. Each one simply meets the standards which were established by its designers. In every case, quality can be quantified and measured. I submit that this principle can be applied with respect to our health care system with beneficial results."

Harold L. Morrison, P.Eng.

Research and technology development, already a high priority with the Alberta government, will expand into the broader health domain and put the province at the forefront of health systems analysis and evaluation. Innovations and outcomes of such studies — developed to increase the efficiency and effectiveness of health care delivery in Alberta — will be highly marketable to other jurisdictions, nationally and internationally.

The scope and quality of care will improve as members of the health care team reassess their roles and responsibilities, and their relationships with each other and their patients, and within the system. Their contributions will be recognized and rewarded.

A champion for all of us

For a variety of reasons, our current health system often does not — and most often cannot — clearly emphasize coordination, communication and consensus in developing comprehensive policy, planning and priorities, and articulating goals and objectives.

This lack of consistent and clearly communicated priorities and directives is viewed as one of our major and immediately pressing problems. While a myriad of program priorities and directives exist, Albertans are denied the benefit of an overall ability to analyze — from an objective perspective — and to plan in the longer term within the current government structure.

The system has difficulty accommodating formal, comprehensive and ongoing mechanisms for reviewing the effectiveness and efficiency of performance, policies, practices, outcomes and programs. Most reviews are conducted on an ad-hoc, reactionary and program-specific basis. Seldom are such reviews shared widely with providers and the public — they become internal working documents which may become lost in the bureaucracy.

Furthermore, not enough attention has been paid — at any level — to tracking the health status of Canadians and Albertans. For the most part, how well we are is documented on the basis of degrees of incapacity and numbers of people afflicted with disability as a result of illness or injury.

In looking at the possibilities for providing some answers to these issues, the Commission looked at several models. These included the Auditor General's Office of both the federal and Alberta governments, the Office of the Surgeon General of the United States, the Economic Council of Canada, the Canadian Council on Social Development, the Wissenschaftzentrum Berlin fuer Sozialforschung (WZB) of the Federal Republic of Germany, the Institute of Medicine in the United States, the Institute for Health Care Facilities of the Future (Canada), and the Institute for the Future (USA). We considered recommending a Premier's Commission every 10 years. All were interesting approaches and provided us with worthwhile background.

"Participatory councils could play a role in organizing interaction. These councils should be composed of people who have both experience and a real interest in coordination, but who have no inherent biases. Technology aids could be of assistance to these councils."
Glenrose Rehabilitation Hospital

The Commission resisted the temptation to suggest the creation of another full-blown bureaucracy. We leaned toward the idea of an overseer who would ensure that the work of others was appropriately directed and focused, that their efforts produced results, and that the results were communicated to interested groups and individuals. We aren't interested in an enforcer as much as a motivator — someone who will champion the causes that became so readily apparent to us in our two-year dialogue with Albertans. We want a catalyst for change who will provide a stimulating and creative environment which fosters information and knowledge. We need an Advocate for a Healthy Alberta — a person who will convince, not force; who will achieve not through might but with wisdom and communication.

The Commission believes that this Advocate must function at arm's length from the government and the delivery system, and be the key player in ensuring that the provincial health system is balanced, caring and responsive. The Advocate would ensure that the monitoring, measuring, analysis and assessment of the performance of the system — and our individual health status — are done. The Advocate would bring health issues to the forefront of the people, the politicians and the media, ensuring that the health system is dynamic and aligned with the changing needs of the people, the providers and the province.

"It is recommended that the Ministry of Health establish and support a 'Citizen's Advisory Health Care Policy' to give consumers input on health care policy in Alberta."
The Alberta Coalition for Universal Health Care

10.0 **THEREFORE, WE RECOMMEND that the Government of Alberta appoint/select an Advocate for a Healthy Alberta to focus on the health status of Albertans as a whole; to review the efficiency, effectiveness, and suitability of our health system; and to set broad priorities; as well as to communicate on health matters with and to Albertans and the government;**

10.1 that the Advocate be given the authority to collect the necessary data from government departments, agencies, and Health Authorities in order to coordinate such activities as may be on-going, and to make recommendations;

10.2 that the Advocate oversee the long-range and strategic planning, and health policy analysis for Alberta, with representatives from each of the Health Authorities sitting in an advisory capacity to the Advocate;

10.3 that the work and the findings of the Advocate for a Healthy Alberta be readily and frequently communicated to Albertans, to the Premier, to Members of the Legislative Assembly, and appropriate government departments; and

10.4 that the Advocate for a Healthy Alberta fulfill his/her mandate during the period of April 1, 1990 and March 31, 2001.

11.0 **FURTHERMORE, WE RECOMMEND that a full review of the success of the Advocate for a Healthy Alberta be conducted by a provincial/national/international panel beginning April 1, 1995 and reporting to the Premier no later than March 31, 1996; and**

11.1 that based on its findings, the review panel either
1) endorse the work of the Advocate and recommend continuance to the end of the term;

2) give it limited approval and recommend continuance, subject to certain changes in direction and structure, and a subsequent review; or

3) assess him/her as ineffective and recommend termination of the appointment within six months; and

11.2 that if the Advocate for a Healthy Alberta does not, or is not able to, fulfill its mandate as described, then a full Alberta Health Institute with appropriate authority and funding be established to carry out the task, reporting directly to the Premier through the Deputy Minister of Executive Council.

Directions for Implementation

The government should bring into existence the Advocate for a Healthy Alberta, establishing a formal mandate, terms of reference, membership composition and reporting relationship, and funding. Funding should be set at a minimum of 0.1 per cent of Alberta Health's operating budget in the first year and rise to 0.5 per cent in the second year of operation and thereafter.

The Advocate for a Healthy Alberta should develop a corporate plan which brings an objective, longer term perspective to the health and health care systems, with a focus on measuring the health status of Albertans. Much of the work should be aimed at ensuring the development of long-range planning and options to assist Alberta Health in fulfilling its mandate and objectives. Detailed information on the health status of residents within various regions would be most useful to local Health Authorities in the delivery of specific health promotion and illness/injury prevention programs, and health care services at the community level.

Information about the health of Albertans, and the effectiveness and efficiency of the health care system should be widely communicated in an easily understood fashion.

The Advocate for a Healthy Alberta should not necessarily do actual planning, policy option development and analysis, and measurement and evaluation, but must ensure that these functions are performed. The Advocate will not assume the functions of others, but will attempt to bring about a more comprehensive, coordinated, pro-active approach. A high level of commitment to the concept will be required from academic and health care institutions, professional and provider organizations, foundations, consumer groups and volunteer agencies, government departments, and advisory committees. If any of these organizations which have a responsibility for collecting data are reluctant to cooperate and participate, then the Advocate will have no choice but to perform these functions.

The Advocate for a Healthy Alberta is an ambitious undertaking...a bold and innovative concept. The success of the Advocate may not be easily achieved, and some bodies may feel threatened by the existence of such an overseer. In addition to the ongoing scrutiny of the public and all stakeholder groups, the Commission has recommended a mid-term review of the effectiveness of the Advocate to protect the integrity of the office, and ensure that the publics' funds are being well-spent.

"It is recommended that, to ensure that program priorities transcend political ideologies, the government establish an Advisory Board (made up of professional and lay community representatives) which could make recommendations regarding program development and provide consistency and continuity through changes in Health Ministers or political parties."
J. Besner

"...physicians have different ideas on how a health care system should be run as compared to non-medical health professionals, the government, or the public. As such, any Regional Council, Department of Hospitals and Medical Care Committee or Ombudsman/Advocate should not be purely medically oriented. This would ensure that Albertans will continue to enjoy a superior health care system and not just a medical care system."
Dr. Gordon J.P. Hensel

"A structural change is necessary in keeping with the need for greater public investment in priority-setting and to facilitate the intersectoral planning and collaboration needed with the complexity of issues in the coming decades."
Healthy Cities Association — Calgary

"There should be regionalization of care in Alberta. Primary, secondary and tertiary care needs to be defined and the institutions identified in which such care will be provided."
Dr. Robert G. McArthur

Local involvement and responsibility

The Commission has promoted and recommended greater personal responsibility and accountability for managing our health and health resources, and those of our families. We believe this concept should be extended to our communities and facilities of care. Our philosophy is that we need to return power to choose and decide closer to Albertans and to communities, in order to nurture the mature, interdependent partnerships we envision as the ideal. There must be coordinated and integrated programs and services, locally planned and directed, reflecting the needs and priorities of individuals and their communities.

The provincial government should concentrate its efforts on setting long-term goals; developing priorities and policies; establishing overall standards; ensuring interregional coordination and communication; and allocating funds on a global basis. Looking to the future isn't easy when you're caught up in the day-to-day administration and determination of routine programs; neither is being responsive and relevant to local needs when you're removed and remote from the action.

The Commission acknowledges the efforts of civil servants within Alberta Health. We have found them to be dedicated and hardworking, co-operative and committed. However, we feel their energies and talents would serve Albertans better if their responsibilities were re-directed as we suggest.

Currently, boundaries for various health services are not common, and the wide mix of services is seldom coordinated at the local level. This results in an inequity in the scope and range of health services between various geographical areas, often leading to either duplication or gaps in service areas.

Our ability to cope with future health care requirements of Albertans is dependent on the mechanisms created to coordinate the activities of government departments, health facilities and agencies, and health care professionals. Management of the system should be based on reliable, current, and comprehensive data, and these data must relate to the broad definition of health, not simply health care.

Attempts at better coordination of health services should be made through collaboration ranging from shared services to complete mergers. One program worth noting is being piloted in southern Alberta and involves various boards joined together as the Southern Rural Health Care Committee — comprised of general and auxiliary hospital and nursing home districts in Claresholm, High River, Little Bow, Turner Valley, and Vulcan, and the Chinook and Foothills health units. Another is the Northwestern Health and Social Services Board, based in High Level, which operates two hospitals, a health unit and mental health services to a district of some 83 000 square kilometres. The Community Resources Centre Board in Medicine Hat co-ordinates services within the city for its more than 40,000 residents. Two examples of the province-wide regional approach to service delivery are the Alberta Cancer Board and the Workers' Compensation Board. All of these approaches should be reviewed in developing a mandate for responsibility of health services delivery at the regional level.

The time has come for government to rethink its role in the administration of our highly complex health care system. Certain responsibilities must be delegated to a more appropriate level of authority. The Commission looked at many models of health care delivery in other jurisdictions, in Canada and elsewhere. Alberta is at an advantage — having a strong foundation and an extensive network of facilities and programs on which to build; and having an opportunity to assess the various aspects of other systems to determine which were the best and most applicable to our vision.

We noted a definite trend toward the concept of regional health authorities, councils and boards. Within Canada, the idea is gaining popularity and has been adopted or is being recommended in Ontario, Quebec, Nova Scotia and, possibly, Saskatchewan. One of the more successful regionalizations has been in operation in New South Wales, Australia since 1986, and it was studied closely by the Commission.

The idea of dividing Alberta into regions which would function as autonomous administrative areas appealed to the Commission given the vastness of Alberta, the differing needs, and the number of facilities and programs already in place. This would allow the regions to respond more appropriately to changes at the local level, and to design the mix of services, treatments and providers to suit their particular constituents.

"The services provided by various health care agencies and institutions should be coordinated on a regional or provincial basis through a mechanism established by the Government of Alberta."

Royal Alexandra Hospital

"A recent publication by Hendrickso in Copenhagen demonstrated a 50 per cent reduction in hospital days, marked reduction in emergency room visits, and increased life expectancy for individuals over age 75 years who were visited on a three-month regular basis in their homes to provide health care and social assistance rather than waiting for the crisis intervention of a visit to a doctor's office or hospital 'on demand'. How many careful studies exploring improved outreach to homes and communities have we conducted?"

Dr. Clarence A. Guenter

"There are few mechanisms available for redirection of funds saved to other program areas. Under the global budget funding approach health care agencies that fail to utilize all of their approved budget funds may eventually have its base budget reduced."
The Alberta Chapters of the Canadian College of Health Service Executives

"We need to plan ahead for changing demography and social conditions and may need to improve after work access to health services e.g. counselling, health promotion, etc. that are normally only 'nine to five' operations."
R.D. Hamm

"It is recommended that there should be input from user groups regarding the requirements and priorities of health care expenditures."
C. Hoffmeyer

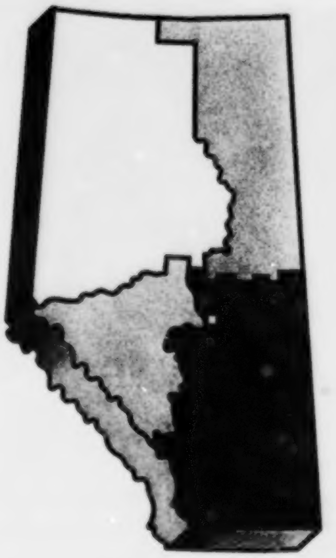
Among the various aspects which we rejected were government appointed boards, boards without executive authority, boards with responsibility for both health and social services, and large population-based regions. We have chosen instead to recommend regional Health Authorities administered by locally-elected boards of trustees. These elected trustees will have executive authority over and accountability for health and health care, but not social services per se — with jurisdiction over manageable-sized regions closely attuned to community needs and priorities.

To function with optimum efficiency, each Health Authority requires executive power to disburse funds to the programs supported in its area. If there is to be a continuum of services provided, then the capacity to shift funds within a region to adequately serve local needs must be in the hands of the local trustees, not the provincial department.

Given our wide range of services and facilities, it is essential that the purposes and functions of each program/service component be coordinated and integrated to foster effective and efficient use of limited resources within each area. Developing linkages, based on specific local needs and demographics, among all segments of health and health care service delivery must be a priority requiring cooperation and a commitment to offer easily accessible services to consumers.

Regionalization is a way of organizing services and making decisions which ensure that those who live in a defined area have a say in what is happening regarding health and health care within their immediate area. It refers to planning, managing, and disbursing of funds within geographic subdivisions. The goal is to move the power to choose, control and decide closer to more Albertans in their communities. The goal is not to put in place a destructively competitive circumstance which simply substitutes current competition for bigger competition. The goal is to put in place a balanced system of regional authorities with relatively comparable strengths and needs, and adequate power.

12.0 THEREFORE, WE RECOMMEND that the province be divided into nine autonomous administrative areas within defined boundary structures, accountable through appropriately named Health Authorities;



12.1 that each Health Authority report annually to the department of Alberta Health on all activities, resource utilization, programs and services, fiscal arrangements and health status within its jurisdiction;

12.2 that each Health Authority board be comprised of locally-elected trustees representative of the constituents, plus an executive director and a department representative;

12.3 that the executive director be a joint appointment of the Health Authority and Alberta Health, but have a direct reporting relationship to the Authority;

12.4 that the framework be put in place for the first election of transitional members to be accommodated during the municipal election process in 1992, with full responsibility transferred to each Health Authority, as appropriate, no later than 1995;

12.5 that each Health Authority devise community care networks to assist consumers in identifying and accessing health and health care information, programs, services, facilities, and treatments available;

12.6 that the mechanism allow for existing hospital and public/community health boards and similar agencies to act in advisory capacity to the Health Authorities; and

12.7 that the role of existing hospital and public/community health boards and similar agencies be determined within each Health Authority jurisdiction.

"It is recommended that as part of a province-wide planning process, formal regional planning authorities be established. These authorities — composed of representatives from the regional health care providers and the community — would be responsible for determining regional health care plans and priorities within the approved provincial framework."
University of Alberta Hospitals

"It is recommended that regional health care planning be studied with a view to the development of mechanisms to provide for all health services planning in a defined region with commensurate authority to implement decisions."
Council of Teaching Hospitals of Alberta

Directions for Implementation

The province will have to develop and enact provincial legislation to create the health regions. The legislation and its supporting regulations should explicitly spell out the boundaries and create a mechanism to coordinate the regions. In determining the regional boundaries, the following principles and factors are worth considering:

— sufficient population size suggests that a full range of health services requires a population base of 35,000 to 100,000 for service delivery to be both efficient and effective in rural areas, and between 100,000 and 500,000 in densely populated areas;
— indicators of community identity include demographic and cultural mixes, networks of referrals for health services, patterns of transport, and trading area for commercial activities;
— common boundaries facilitate planning and coordination of services, especially if within existing boundary structures. Consistency with municipal boundaries is especially important for a number of reasons. Municipal governments could play an important role in public health service delivery and the provision of services. Additionally these areas are used as bases for collection of statistics. Demographic and health related data are basic to the planning and research activities that will influence decisions by Health Authorities; and
— sufficient health resources — people, providers, programs and facilities — are necessary to justify regional management. Potential should exist to improve health service delivery within Authorities by redistributing resources, streamlining existing functions, and making additional programs and services available.

The Commission recommends boundaries for the nine Health Authorities which follow, generally, existing municipal boundaries. These are known and understood by Albertans. As well, the upcoming first election of trustees during municipal elections in 1992 will be facilitated by this approach without great difficulty. Our suggested boundaries meet the principles and factors outlined and are worth consideration by government. Furthermore, the data collected within the boundaries — historical and ongoing — will provide an exceptionally fine base for the Health Authorities to establish their priorities to begin compiling information for health status reports.

Alberta Health will not be the direct service provider, but will fund, coordinate and monitor regional activities. Additionally, the department will set provincial objectives and goals, establish minimum standards, and supply information and expertise. It also will negotiate regional budgets with each Health Authority, and provide inter-regional coordination. Major capital spending would remain a provincial responsibility.

Since the Authorities will report annually to the department, but will manage the health system within their regions, there will be a changed role for Alberta Health. The department will require some reorganization, and existing resources will need to be reallocated between various functions in view of this new role.

To meet community needs through innovative programs, each Health Authority must be able to develop appropriate funding mechanisms, and will be held accountable for how they spend their resources. If they spend more than they have, they will have to find ways of either increasing their efficiencies or raising more resources. Under normal circumstances, they should not expect to return to the department for additional funds. We do not recommend that Authorities be given the power to levy a supplementary property tax to raise additional revenues beyond those they have negoiated with the province. Albertans do not want a new supplementary requisition from their property. However, a variety of other avenues to raise funds should be open to the Authorities.

To ensure provincial consistency, each Authority will be required to provide services — either directly or by arrangement with other Authorities — for health promotion, illness/injury prevention, primary and secondary acute care services, rehabilitative services and long-term care.

Alberta Health will continue to be responsible for the provision of highly complex, tertiary care and specialized services, and will determine which should be organized at the provincial, interprovincial, and international levels.

Legislation will be required prior to the next municipal election process in 1992 to accommodate the election of Health Authority trustees in those regions that are ready to proceed with transitional boards. While selection of candidates will be part of the nomination process, the Commission would urge selection of persons representative of constituent groups within the region. We further suggest that legislation allow for at least one trustee, between the ages of 16 and 21 years, to be elected from the youth of the region.

"It is recommended that increased regionalization be developed in Alberta's health care system and that regional councils be appointed to assist the Department of Health in decision-making based on locally determined priorities."
Foothills Provincial General Hospital

"It is recommended that communities be provided with adequate funding and authority to develop health services according to their needs and priorities."
Red Deer Regional Mental Health Council

"Service delivery plans must be derived with full input from people who know what works and what does not work at the service delivery level. We must have plans that work because it is human suffering of an enormous magnitude that we are attempting to reduce."
Alberta Hospital, Edmonton

"A good system must enable continuing and comprehensive care to be given through coordinated services. There can be little doubt in any gerontologist's mind these days that the elderly are happier in their own homes. Equally obvious is the fact that without the support of a hospital-based department of geriatric medicine it may well be impossible to achieve this independence for the elderly person."
Dr. David Skelton

"Costs dictate that we must seek new innovative methods of delivering health care. Preventive medicine, public education and research should be promoted."
Dr. Lorne R. Hatch

"It is recommended that, with regard to establishing a new health care delivery system with a Health Authority as its central unit of administration, it should be continuously recognized that its mandate is to prevent illness, thus reduce utilization for which it will be rewarded, and as well to provide an equitable level of care to all of its constituents within its boundaries."
K. Mark

While the Commission has not been specific regarding the numbers of trustees on each Health Authority, a board consisting of no less than seven and no more than 13 would seem appropriate. The executive director, jointly appointed by the Health Authority and Alberta Health, would act as the liaison between the two, ensuring that provincial standards are maintained within the region.

Consumers will be assisted in identifying the services they need through information and referral mechanisms — functions not facilities — known as "community care networks." The structure of such a network may vary from Authority to Authority, and larger centres will require a number of them, but the functions outlined in our recommendation should be addressed by all community care networks. These include:

— liaison between patient and health care systems;
— liaison between hospitals and community care systems;
— registration, information and referral for all types of health and health care programs;
— single point of entry for rehabilitation and long-term care, homecare, respite care, adult day and night care, palliative care;
— documentation of the needs of the community and communication of priorities to the regional Health Authority;
— dissemination of health promotion and illness/injury prevention information; and
— collaboration and integration with appropriate social and other services.

These functions may be implemented in a variety of ways depending on the community and background. In fact, the network may simply be a series of formal linkages among existing groups with some additional resources available through the Health Authority.

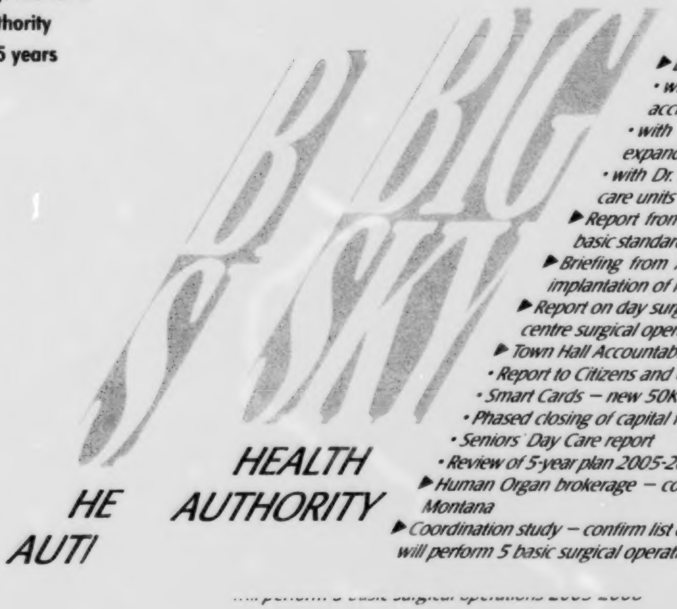
Because Alberta has many rural hospitals, it may be that they evolve to become the centres from which community care networks provide assistance. In large urban centres, the community care network might coordinate, for instance, the functions of the "hospital without walls" concept of homecare services. In some communities, the network may integrate the functions of current health units. In other communities, the functioning unit may be housed within an office building or shopping mall. The important point is that the community care network fulfills functions, it does not necessarily become a facility with a large permanent staff. It is a way of reorganizing much of what we have, rather than adding to it.

Regions will depend upon provincial standards for licensing of professions and occupations, but access by professions and occupations to facilities for purposes of work will be at a regional level rather than at a facility level. Committees which determine the right to practice in institutions or regions will be made up of regional representatives rather than representatives from a particular facility. Within health care facilities, peer review processes are part of and necessary for quality management decisions. Issues of risk management and quality assurance must be dealt with in an atmosphere of total candor and without fear of reprisal by those involved. Therefore, individuals participating in such peer reviews should be protected from possible litigation in respect to their contributions to the process. A protective mechanism currently operates under British Columbia laws, and appears to be helpful in improving the candor, objectivity and usefulness of peer review. Alberta should change its laws accordingly.

Town hall meetings for consumers could become annual accountability sessions which would provide the Authorities with a forum for reporting on activities and receiving community comment. Annual, regional reports would be widely communicated to the public and the department in a standardized format.

"It is recommended that a regional approach be taken with regard to health care planning, and that these in turn, feed in and become part of the provincial health planning picture."
Grey Nuns of Alberta

Sample Agenda for a Health Authority meeting 15 years hence.



MEETING AGENDA • 2005/5/15

- ▶ *Location of two emergency departments as between six health centres in the region.*
- ▶ *Discussion via Satellite*
  - *• with Alberta North Health Authority re: their farm accident prevention outreach program*
  - *• with Saskatoon Regional Health Board re: their expanding links with local volunteer groups*
  - *• with Dr. Hito Yokima in Tokyo re: portable intensive care units*
- ▶ *Report from Provincial Department of Health re: new basic standards for immunization against ovarian cancer*
- ▶ *Briefing from Alberta Ethics Centre re: guidelines for implantation of micro processors*
- ▶ *Report on day surgery trends (now at 80% of all health centre surgical operations)*
- ▶ *Town Hall Accountability Meeting 2005/6/20*
  - *• Report to Citizens and Question Period*
  - *• Smart Cards – new 50K version – confidentiality*
  - *• Phased closing of capital facilities/ beds*
  - *• Seniors' Day Care report*
  - *• Review of 5-year plan 2005-2010 – citizens' responses*
- ▶ *Human Organ brokerage – cooperation with B.C. and Montana*
- ▶ *Coordination study – confirm list of health centres that will perform 5 basic surgical operations 2005-2008*

...will perform 5 basic surgical operations 2005-2008

Health Authorities should be bold and innovative in their approaches to providing health services. Some Health Authorities might explore and encourage the development of accredited independent facilities within their boundaries. Such innovations would include, but not be limited to:

— new types of primary care arrangements:
— improved coordination and appropriate expansions of treatment and care in the community and at home: and
— application of satellite and other communications technology in the areas of distance learning, consultation and consumer awareness programming.

For example, there may be merit in moving some services out of hospitals into smaller, specialized, less expensive, and friendlier options like surgicentres, birthing centres, pain clinics, diabetic and heart clinics.

The Commission wishes to stress that the Health Authorities will be expected to work closely with existing hospital and community health boards and agencies toward the common goal of providing an optimum level of service to the people within their communities. Further, it will be incumbent on the Authorities, in conjunction with these existing boards and agencies, to determine the most appropriate mix of roles within each region.

Dependable dollar levels

The Commission heard concerns from a number of Albertans — individuals, providers, administrators, professional organizations — about funding of health care services. Few are pleased with the current system. All are aware that costs are escalating and that our resources are limited. A concerted effort by all stakeholders is needed to use available dollars in a far more efficient and responsible manner. *Don't spend more…spend better!* has become the rallying cry.

The present institutional funding system in Alberta is largely a global funding approach which provides grants to hospitals and other agencies to operate approved programs. The basis for determination of institutional budgets includes historical costs, plus adjustments to recognize inflation, collective agreements, and occasionally significant changes and new programs.

"There must be an alternative health care delivery system established — one that is affordable and effective. There must be a feasibility study in this regard centering on the inclusion of certain services which are not currently allowed into tax supported facilities (example — Doctors cannot, by law, cooperate with chiropractors)."
The College of Chiropractors of Alberta

"It is recommended that volunteer agencies, consumer groups, industry, business, education, health and social organizations all have a role to play in the health of the community."
The Heart Health Task Committee

"It is recommended that, with regard to health care, we have to analyze the situation, see what we are spending too much on, and find a way to either spend less on it, get more for the job, or article, or eliminate it."
D. McKeen

The nature of the funding system causes many to focus on the number of beds and occupancy rates as being of great importance, with the majority of measures and controls placed on inputs such as staffing levels and hours, drugs, equipment, and housekeeeping costs. One of the consequences is that hospitals attempt to balance budgets by closing beds and operating rooms, which results in long waiting lists for procedures.

The Commission sees the necessity for major changes in the funding structure with the emergence of the Health Authorities. For instance, funding of hospitals by Health Authorities should be based on level of complexity, level of illness (acuity), and number of patients treated. In fact, Alberta Health, in consultation and conjunction with department, hospital and professional representatives, is currently attempting to develop an equitable and effective process for allocating acute care funding. An 11-member steering committee wants to change the budget focus from inputs to outputs, and eventually to outcomes — hospital budgets would recognize the costs of in-patient treatment, out-patient treatment, facility support, and other components such as education, research and shared services. Hospitals would be paid an average cost per case adjusted for severity, and hospitals performing services at lower than average cost would retain the difference as a reward for efficiency. The incentive would encourage staff to review cost differences to determine the relative merits of different ways hospitals provide services. The acute care funding project also is taking a hard look at ambulatory care services — emergency treatment, scheduled out-patient clinics and day surgery clinics — and compiling data never before collected on costs, management and delivery to develop a separate funding system. The Commission is very encouraged by these efforts and other suggestions being put forward for discussion by the members of the acute care funding project team. Preliminary indications are that their recommendations are consistent with our own regarding changes to the funding structure.

Combining this type of funding with programs such as the Value Incentive Program (VIP) at the Foothills Hospital in Calgary, which decreases length of stay without compromising quality, will ensure that hospitals are appropriately funded and staffed for jobs that they actually perform. This would decrease inequitable funding for inefficient hospitals or those not working to capacity.

The advantage of a revised funding procedure, from the patient's standpoint, is that hospitals have the appropriate personnel and equipment to perform necessary services in a timely fashion. The Commission also supports the approaches recommended for institutional funding by the Advisory Committee on the Utilization of Medical Services - 1989 (see Appendix IX, Volume III).

"The medical profession must realize the costs to society when 'pills' become the solution."
M. Kelly

"The desire of local hospitals to have as many sophisticated programs and equipment as possible is understandable. The temptation of politicians to yield to such local demand is great. The end result, however, is duplication and great expense.

It is recommended that high cost programs and equipment be centralized. In many instances it would be more economical to centralize sophisticated programs and provide transportation and temporary accommodation for family members."
City of Medicine Hat — FCSS Advisory Board

"The essential problem in the present system is that it is open ended: the cost is determined by the demand, and there are no restraints on demand such as might be brought about by a charge to enter the system, or a contribution to maintenance once the system is entered."
F.J. Covill

"It is recommended that the use of rural hospitals with low occupancy rates be maximized. E.g. halfway houses, shelters, hospice care, adult day care."
Big Country Health Unit

"It has been set out... that the rate of growth in institutional services should be reduced. However, in attempting to reduce the rate of growth, one should look for facilities which are able to respond to society's growing expectations for environment and program capability. This will avoid the 'tenement housing' syndrome and create incentives for positive market forces. It will also help all parties focus on the quality rather than the quantity of services within the sector."
Alberta Long-Term Care Association

In general, the Commission believes that hospitals should be classified and funded according to whether they provide all or a mix of services — general care, general and specialty care, and specialized active care. Major medical and referral centres should not be performing services that can easily be provided in other facilities. Hospitals should receive funding for other programs and services. Therefore, additional costs of research, including personnel, should be financed through negotiation with government, research agencies and the private sector. As well, any hospital or health agency, at any level, providing teaching or training of health care personnel should receive supplemental funding, as appropriate. Classification and funding will be negotiated between hospitals and the Health Authority and approved by Alberta Health.

Information about hospitals — their classification, rate of success and failure with respect to procedures and medical problems, and volume of services — has to be publicly presented by Health Authorities. Consumers should know what different hospitals and agencies are capable of providing to ensure, whenever possible, that they are treated in the most appropriate facility closest to their home or community.

Health Authorities could designate some facilities as "multi-level" to accommodate a mix of long-term, rehabilitation, respite and acute care, particularly in rural areas. In these smaller communities, a broad range of needs are usually met within a single local facility. Designation and appropriate funding of the beds in these facilities in accordance with actual utilization would allow more efficient use of these community resources. Through personalized and direct funding, and appropriate case-mix funding, such a facility would have the flexibility to meet the needs of that community. To the government this would mean maximum utilization of the many hospital beds in the province. To the patient this would mean coordinated community care, integrated with necessary hospital care.

The Commission believes that, if funds for the building of new hospitals are not constrained, the ability of the provincial government to provide funds for the operation of existing hospitals and for community services will become more limited. It is not well-known that approximately one-third of the capital cost of a hospital is needed each year to run that hospital once it is fully operational. Essentially, this means that every three years, we "build another hospital" through these operating costs which are ongoing for the life of the facility. Obviously, our ability to spend dollars on non-institutional, community-based programs will be severely inhibited if the institutional side continues to grow. If more money for non-institutional programs and for running existing facilities is to be found, the Commission feels it would be best for government to curtail investment in new, as yet to be approved, hospitals at least until the year 2000.

"My view you know is that the ultimate destination of all nursing is the nursing of the sick in their own homes... I look to the abolition of all hospitals and workhouse infirmaries. But it is no use to talk about the year 2000..."
Florence Nightingale

The Commission also heard the concerns of stakeholders regarding the uncertainty of funding. We believe that the funding system must be stable and predictable. The current budgetary cycles do not allow for meaningful medium to long range financial, physical, program and manpower planning. The various methods of funding capital and operating costs are inconsistent and difficult to rationalize — they do not always emphasize a consistent vision of health and the health system. Health Authorities should be in the position to negotiate three- to five-year budgets and develop five- to ten-year long-range plans in an atmosphere of confidence — knowing that funding will not fall below a certain level. There should be some measure of guaranteed commitment if Health Authorities are to operate and deliver an appropriate quality and variety of health care services.

"We know in our hearts that we are in the world for keeps, yet we are still tackling 20-year problems with five-year plans staffed by two-year personnel working with one-year appropriations. It's simply not good enough."
Harlan Cleveland
Source: The Futurist, December 1985

Furthermore, the vast bulk of medical services in Alberta is provided by physicians and other practitioners and funded on a fee-for-service basis. While other arrangements such as sessional payments do exist in specific instances, this represents a small proportion of the total practitioner funding system. A minority of practitioners, employed by hospitals, is paid by salary. Incentive bonuses or other awards are not given by hospitals.

"The main problem with the German health system is that the controllers of the money, the insurance funds, have insufficient control over the providers of health."
Source: European News

Physicians have been assigned the major responsibility for admission, diagnosis and treatment of patients. As a consequence, the fee-for-service system, while it rewards productivity, may also encourage utilization — some of which may be unnecessary. Payment mechanisms must be the responsibility of the Health Authorities who will determine the best mix of remuneration methods in negotiation with health care providers. Careful consideration and implementation of new approaches will ensure improvements in the delivery system.

The Commission acknowledges the complexity of the system and the difficulty in developing a funding mechanism that addresses all aspects of the system. We concede that no single funding system for institutions and practitioners will be perfect and satisfactory to all stakeholders. Nonetheless, improvements can be made to the existing systems. It is imperative that review and revision to the funding system occur through consultation and cooperation between Alberta Health and all interested parties.

"It is recommended that a formula funding system based on regional needs and volume driven be considered."
Medicine Hat Regional Hospital

13.0 **THEREFORE, WE RECOMMEND that the Government of Alberta declare health and health care as high priority services, including those which are defined as basic to the Alberta Health Care Insurance Plan, and thus ensure and protect budget allocations during periods of economic restraint; and**

13.1 that Alberta Health disburse health and health care funds directly to individual Health Authorities which are responsible for provision of services, including appropriate methods of compensation, within their administrative areas.

Directions for Implementation

"It is recommended that health care should be a priority with the government and cutbacks in this area should be kept to a minimum."
Women of Uniform

The Commission believes that lack of stability of funding deters the administrators of the provincial health care system from planning beyond the short-term. Long-term planning is an essential element of fiscal responsibility. To stifle this activity is contrary to the principles and essentials which formed the basis for the Commission's vision of future health care for Albertans.

We recognize the volatility of the provincial economy and appreciate the significance of the existence of the Alberta Heritage Savings Trust Fund. Estimated annual revenue generation is obviously the determining factor in budget allocations for social programs. Nonetheless, we maintain that specific protection is necessary in the area of health and health care services. The Commission wants health and health care, including basic coverage under the Alberta Health Care Insurance Plan, to be declared high priority services.

Despite royalty funds previously accumulated in the Heritage Fund now being directed to the general revenues of the province, operating funds for health care have faced cuts in years of economic downturn. Government should explore the feasibility and advisability of various methods of stabilizing health care funding to even out budget uncertainty — particularly with the establishment of the Health Authorities which will be mandated to manage and disburse funds, and expected to long-range plan.

For instance, other provinces — British Columbia and Manitoba — have established budget stabilization funds for protection against periods of economic restraint. Both accumulate monies during "exceptional revenue" years and add proceeds from the sale of Crown corporations. Alberta might consider something similar, but earmarked for health. Another possibility, during restraint, would be to channel lottery fund profits into operating budgets of only those Health Authorities which may face a short-fall. Increasing premiums is an additional option, as would be cutting back on certain capital projects.

"It is recommended that a 'Health Care Legacy Fund' should be established to give Albertans an opportunity to make tax-deductible donations to Alberta Health Care."
J. Laurie

Health Authorities should be allocated global budgets, including an incentive component, according to their needs and priorities. Regions would be funded on a longer term basis using three- to five- and five- to ten-year plans. Such global funding could be per-capita based, adjusted for demography, epidemiology, and other socio-economic factors.

"It is recommended that, with reference to the [proposed] establishment of a Crown Corporation to regionally manage the health care system, funding from the Crown Corporation should be established as a regional base with each region receiving a global budget to operate all health care needs for the region. This budget is to be determined by the utilization needs and program allocation in all regions. Each region will prepare an annual budget of its expected needs, approved by the Board of Directors."
D. Dooley

Obtaining operating and capital funds would involve the negotiation and approval of a contract between Alberta Health and each Authority for delivering services during a minimum of the next three fiscal years, dependent on approval-in-principle of the long-range plan. This would allow Authorities to manage their full budget on a global not line-by-line basis; and to negotiate contract services within the region as appropriate to carry out their plans.

An incentive component might be established, for example, to allow for surpluses generated through cost-efficient provision of agreed-upon services to be rebated to individuals and/or families participating in the programs of the Authority, to member-organizations in the region, or to the provincial government on an agreed-upon basis. For example, if the overall annual budget for an Authority were $200 million and services were provided satisfactorily with a savings of $25 million, the Health Authority could decide to return $5 million to the government, $10 million to the individuals and/or families, and retain $10 million to be distributed as deemed appropriate by the regional board. Within the $10 million being rebated to participants, $7.5 million could be rebated to all participants on an equal basis, while $2.5 million could be rebated as a bonus to those individuals/families who were awarded "health points" for maintaining healthy lifestyle behaviours which resulted in less cost to the system.

"...I believe that too much emphasis and capital has been placed on capital (physical) investment. Successful business today invests in people (not necessarily professional) with more and more functions being handled by our very rapidly growing technology."
Aaron Shtabsky, Q.C.

"It is recommended that a variety of sources of funding be identified and utilized. These to include: lotteries, user fees, additional targeted health premiums, local campaigns in the private sector and increase in federal funding."
Health Unit Association of Alberta

Health Authorities would be allowed to raise additional funds to supplement the approved provincial budget. Any variety of methods might be used — they could borrow, sell debentures, hold lotteries, launch direct appeal campaigns, establish a fund-raising foundation, or introduce user fees for services outside the Canada Health Act. Elected trustees managing the Health Authorities would be responsible and accountable to their constituents for determining extra services and distributing these resources according to local priorities.

Alberta Health would have to institute special mechanisms to fund tertiary and specialized health care services that do not fall under regional jurisdiction, but are considered provincial in scope. Currently, the Minister and the department receive advice on specialized patient-care facilities, professional skills and high-cost medical technology from wide and diverse sources — professional organizations, hospital boards, individuals, and specifically-created standing and ad hoc committees. There is little or no effective, ongoing coordination of tertiary services within and between specialty hospitals, or with acute care hospitals. To make judgements on adopting new advances in treatment more effectively, the Commission suggests that the people, the system, the regions, the department and the government might be better served by a provincial advisory council on tertiary care services. Reporting directly to the Minister, the council should include representation from the medical and nursing faculties of the universities and other post-secondary institutions offering health disciplines; the Alberta Heritage Foundation for Health Research and the Alberta Foundation for Nursing Research; the department and the Advocate for a Healthy Alberta; and, most importantly, consumers. The council would develop criteria for funding and development priorities based on the impact of proposed or needed services on Albertans. Consultation and coordination with jurisdictions outside the province is strongly advised.

Regional responsibility for negotiating compensation would allow Health Authorities reasonable flexibility to attract service providers to their areas. A more mixed system of remuneration methods which benefit from the strength of each payment method is a desirable objective. Fee for service, contract for service, and salary are all reasonable forms of reimbursement, and should be so recognized by both payers and providers. It is not necessary to have one particular system for all providers, in all parts of the province. Basically, every method of payment has built-in incentives. The development of incentive-based systems could create behaviour which moves the system toward provincial and regional goals.

Methods other than fee-for-service should be investigated and implemented where there is evidence that such a payment system would result in a more equitable compensation for providers...better service to consumers...and at a cost which is acceptable and affordable to the Health Authorities.

RESEARCH AND TECHNOLOGY: A HEALTHY CLIMATE

The foundations for the growing research and technology sector in the province were laid in 1921 with the establishment of the Alberta Research Council. While much of the activity has centred on the technologies associated with the natural resource-based industries and earned Albertans an international reputation for their expertise, recent years have seen the emergence of more than 1,000 advanced technology firms involved in various fields. The efforts of more than 35,000 people are being applied in fields like medical research and biotechnology, telecommunications and electronics, computers and software, and advanced materials development.

"Provision of excellent health care for all Albertans requires research and the application of research findings."
Faculty of Home Economics, University of Alberta

The cooperative partnership that has generated this activity and created this healthy climate involves the private sector, the universities and other post-secondary institutions, and the provincial government. Since 1983, the government has invested more than $1.6 billion to support scientific development. The commitment in 1987/88 was $240 million, resulting in the highest per capita expenditure of any of the provinces.

The major boost to bring medical research to the forefront in Alberta was the establishment in 1980 of the Alberta Heritage Foundation for Medical Research. Interest earned on a Heritage Fund endowment of $300 million has been used to create a world-class research environment. The Foundation currently awards about $35 million each year — about 40 per cent is used to fund state-of-the-art projects which have attracted internationally acclaimed researchers to Alberta; 30 per cent is allocated to training young scientists; and the balance is for equipment and a small amount for administrative expenses. In the past decade, the Foundation for Medical Research has spent $54.8 million on two major research facilities — $26.8 million at the University of Alberta in Edmonton, and $28 million at the University of Calgary.

"The programs of the Foundation have produced a unique medical research milieu that is likely not matched elsewhere in the world."
Dr. Jack Laidlaw, Chairman, International Board of Review, Alberta Heritage Foundation for Medical Research

Overall, the Alberta Heritage Foundation for Medical Research has funded the activities of more than 145 renowned scientists in Alberta, and has supported the studies of close to 3,000 students since 1980. This is a remarkable achievement for one organization. Clearly, Alberta is moving to be a major scientific "brain trust", thanks in large part to the introduction of the Alberta Heritage Foundation for Medical Research.

AHFMR has contributed more money per capita for medical research than any other province, state, or country in the world. (As of January, 1989, $275 million.)
AHFMR Brochure

"At the national level, Canada spends more than $6 billion a year on nursing services, yet financial support of nursing research at the national level has been very limited."
Alberta Foundation for Nursing Research

"It is recommended that there is encouragement of medical research and development in the province to compete with the Swiss and German companies."
Alberta Society of Orthopaedic Surgeons

"...it seems essential that somehow we make a very serious effort to help the public at large to understand that high cost technology should be directed toward potentially positive outcomes and not used as pacifiers to satisfy ourselves that we 'have done everything we could."
Mr. G. Vanhooren

The Commission would like to remind people that not all doctors are physicians. Indeed, the most substantial contributions to research in the health and medical fields have been made — not by medical doctors — but by research scientists who have earned doctoral degrees (PhDs) in a variety of disciplines. Some medically trained doctors do conduct research, but relatively few are attracted to the scientific arena. Other worthwhile innovations in health care research are made by nurses who have PhDs. The efforts of researchers and scientists are complemented by highly skilled technicians and technologists who specialize in a variety of disciplines.

The major funders of health research in Alberta are the provincial and federal governments, the Alberta Heritage Foundation for Medical Research, the Alberta Foundation for Nursing Research, Alberta Health, and national bodies such as the Medical Research Council, the National Research Council, and the National Health and Research Development Program. For mental health research, the major funder is the Provincial Mental Health Advisory Council. Other major sources of funding are the pharmaceutical industry and non-governmental organizations. Indeed, volunteer organizations such as the Canadian Cancer Society, the Canadian Heart and Stroke Foundation, and many others provide additional sources of revenue, raised entirely through the efforts and energy of hundreds of thousands of volunteers in Alberta, and throughout Canada.

Almost all of these activities have combined to heighten the awareness and prestige of research and technological advances in the medical field. Alberta is seen as a very exciting place for such researchers — but we must broaden our horizons to include research in the health and health care systems. Thus, the province would enhance its ability to attract, maintain, and nurture a wider variety of high calibre researchers, encompassing the entire health care domain.

The need for health technology to support the health system is understood by all Canadians. Society's ongoing demands for higher quality health care has encouraged the development of a large, international medical device, pharmaceutical and toiletry industry, projected to be worth $100 billion in 1990.

The Commission is convinced that there should be increasing concern about evolving technology. A comprehensive, continuous, and consolidated assessment of technologies should be in place. This assessment should include scientific, medical/clinical effectiveness, efficiency, and safety; current necessity and effectiveness, including direct and indirect costs; and social/psychological impact including possible legal and ethical dilemmas. The result of both the research and technology assessment should be communicated in an easily understood format to a wide audience throughout the health and health care community, and to the Health Authorities.

The fundamental process of selecting and collecting information, combining information from different sources, and disseminating that information is seen to be at the heart of the technology assessment process.

In Canada, technology assessment activities occur at both federal and provincial levels. The federal government's Health Protection Branch assures the evaluation of drugs and some medical devices for safety and effectiveness prior to authorizing their general use. The Canadian Standards Association also evaluates medical devices from the standpoint of electrical, radiation, and mechanical safety before granting their seal of approval.

In Alberta, health technology assessment activities are done on a voluntary basis for various purposes. For example, in a medical teaching centre, clinical trials may be undertaken with or without special funding at the initiative of clinicians, post-graduate students, researchers and so forth. The results of such studies are usually published in journals. Many of the studies compare the outcome or effectiveness of one clinical technology to another. In other situations, such as the assessment of orthotic and prosthetic devices, the merits of a particular technology may be assessed by simple observation combined with trial and error. As well, it is common to share experiences and information through consultations, teaching sessions and conferences. In selected areas, the College of Physicians and Surgeons, the Alberta Medical Association and various other professional groups may issue guidelines for the use of certain technologies that can be said to represent the results of an evaluation process.

The general conclusion is that health technology assessment in Alberta is a sporadic and spontaneous type of activity. In the case of costly new equipment, or programs embodying new forms of technology, the assessment process is largely a matter of writing reports based on published sources in an effort to convince government officials that the sought-after technology is worthwhile, beneficial and probably cost-effective. Government's response is usually to ask a few questions and seek clarification, or to form an advisory committee to make recommendations. But such advisory committees are almost never provided with the funding needed to conduct their own independent assessments.

Historically, the constraints on technology have occurred because the provincial government channelled most new technology through the hospital system by maintaining control over operating and capital budgets. However, hospitals are increasingly turning to private fund-raising efforts to elude the restrictions of provincial budgetary controls.

"Solutions to some of today's problems in health care have appeared in the research literature but have not yet been applied in practice. The reason for this is that change requires some impetus or energy to initiate the change. Also, individuals tend to be conservative and avoid changes that are disruptive to the normal or traditional ways of doing things.

It is recommended that incentives be provided to health care organizations to incorporate research findings into their operations."

University of Alberta

Broadly speaking, since the ability to generate funds may not necessarily correspond with need, there is some concern that the resulting resource allocations may not serve the interests of a balanced system — nor improve the quality of care in the most timely manner. There are signs of increasing friction between government and providers of care about the funding and provision of health services in general, and about the introduction and utilization of health technology in particular.

In response to many of the concerns expressed by various authorities regarding the lack of a technology assessment process to guide government's planning and resource allocation decisions in health care, Alberta Health initiated a process of enquiry in this area. The results confirm the view that the government should take the lead in setting up and supporting a health technology assessment function in this province.

Alberta Health has a small group of experts, who advise on new technology, but do not have a formal mandate or adequate resources to do as much as should be done. Currently, efforts initiated by the department to coordinate such activities at the provincial level are steps in the right direction. However, no province currently has a formal coordination mechanism to cover technology in its broader framework with the credibility and competence necessary to involve stakeholders to the extent that the results of the assessment would be respected and implemented.

"It is recommended that encouragement is needed for people to become involved in research, to evaluate and to share their findings."
Minburn/Vermilion
Health Unit

The Commission believes the time has long-passed when ad hoc responses to advancing technology are a sufficient base for decisions. We need mechanisms in place which will involve assessing health technology in its broadest sense. We must review and synthesize scientific information concerning health, economic, social, and ethical issues. Alberta needs a formal, reputable agency to act as a clearing house for such information.

"For at least 14 years the statement has been made that half of what the medical profession does is of unverified effectiveness. Surprisingly, there is no meaningful evidence to disprove such a claim. In the words of one scientist, the fundamental assessments of whether procedure A or B works better, just haven't been done."
Dr. R.Y. McMurtry

Realigning research

Research involves investigating and inquiring about something in a systematic way. There are many types of health research. One type examines causes and treatments of diseases that influence the health status of people; another examines how health services are delivered; and yet another deals with how useful health services are. The purpose of this research is to increase our general knowledge of health and health service delivery. Overall, unfortunately, such research is viewed more as an adjunct to the health system rather than as an integral part of the system.

Relatively more resources — money, people, and facilities — are devoted to the diagnosis and treatment of illness, and the search for cures. As well, most resources are devoted to basic and laboratory research, with far lesser allocation to clinically applied research, measurement of treatment outcomes, research related to health promotion and illness/injury prevention, or investigations of health service delivery.

In fact, other than the Alberta Foundation for Nursing Research, research support within the broader definition of health is relatively sparse in Alberta. This means that little study is occurring on the impact of environmental, social and economic policies on the health of individuals, families and communities, and on conflict prevention and management. There is little attention paid to researching alternative health systems and health providers, managing the health system, and possible future health systems.

Not enough emphasis is placed on evolving and critical issues such as the problems of adolescents and their parents, aging, addictions, Native health, and mental health. Groups with specific needs should advocate for research in these areas. Research into special problems will have to be balanced with the need for research in the areas of promotion and prevention. In turn, the level of clinical and biomedical research will have to be balanced with the social sciences, and the management and delivery of health and health care services.

Health research must be more aptly reflected in advanced education programs which train people in the health disciplines, as well as administration, computer sciences and other appropriate areas. Employment opportunities would expand to include different types of professionals to accommodate innovations in the health and health care systems industry, developed through Alberta-based research activities. For example, some communities may request a "hospital-in-the-community" service rather than building a new hospital once the results of research and evaluation have been published and discussed. Other communities might want to convert their small hospitals into primary health and extended care centres if the research shows that the citizens can receive better care by stabilizing and transferring acute care cases, while attending locally to those requiring long-term care.

There has been no overall direction for this kind of health research in Alberta. However, there is much better research direction for basic laboratory research, especially research funded by the Alberta Heritage Foundation for Medical Research and by national agencies.

"It is recommended that an endowment sufficient to properly fund a world class Injury Prevention and Research Foundation be transferred from the Heritage Saving Trust Fund and added to the Alberta Heritage Foundation for Medical Research (AHFMR) and earmarked specifically for injury prevention and control research projects."
Injury Awareness and Prevention Centre, University of Alberta

"It is recommended that research money should be made available to study the health needs of the elderly, focusing on disease prevention, nutrition, drug interactions, environmental diseases, adverse and positive effects of mega-vitamins and other over-the-counter drugs and alternative therapies. Clinical trials should include all age groups."
Consumers Assocation of Canada

"There is a need to develop a research base in order that sound decisions be made. Too often, there is no data available to determine the need or desirability of establishing and implementing change in the health care system."
University of Calgary — Faculty of Medicine

"It is recommended that the Government of Alberta initiate an Alberta Heritage Foundation for Primary Health Care Research."
Sturgeon Health Unit

Research is an invaluable part of a balanced, caring, and responsive system and a prerequisite for the system to be virtually self-renewing and sustainable. The Commission believes that Alberta's efforts must increasingly emphasize research into health care systems, health status, intervention outcomes, health promotion, and illness and injury prevention — while maintaining research into the causes, care and cure of diseases.

Ideally, much health research should focus on people and their needs. It provides us with information regarding effective alternatives, and with knowledge to help us make choices. Through research, Albertans — individually and collectively — should learn to understand and respond to the challenges of change. In fact, research should provide Albertans with the opportunity to face, direct, and even instigate, some of these changes.

"It is recommended that medical research bodies include suicide prevention as a legitimate area of funded study."
Suicide Prevention Provincial Advisory Committee

Results of research then would both identify and better serve our needs, and research issues and topics would match the health and the health care concerns of Albertans. Priorities would be established and reviewed on an ongoing basis with suggestions from individual Albertans, as well as those involved in the health and health care fields.

Through a process of information transfer, and dialogue and discussion, research done in Alberta would reflect the the priorities set by Albertans — consumers, providers, managers, business people, educators, academics, and researchers. It would also be communicated on a regular basis and in an understandable form. This would increase opportunities for the findings to be put into practice. For example, social marketing research may reveal that health promotional programs are more effective if they are focused on one particular group — or it may show that the more generalized, simple message is more effective with topics such as exercising to keep our bodies healthy; but not with other topics such as learning to cope with the stress created by a family member suffering from substance abuse.

"It is recommended that published worldwide research should be made easily available at a central facility."
P. Vipond

The process of receiving input from many to help set priorities in research, and communicating the results of this research to the public will result in heightened awareness and familiarity with the multiple roles research plays in the health and health care system.

14.0 **THEREFORE, WE RECOMMEND that the mandate of the Alberta Heritage Foundation for Medical Research be reviewed and expanded to include research into health care systems, health status, intervention outcomes, and promotion and prevention;**

14.1 that the name of the Foundation be changed to the Alberta Heritage Foundation for Health Research to reflect its expanded mandate;

14.2 that funding to the Foundation from the original Alberta Heritage Savings Trust Fund endowment be increased annually at a minimum of one per cent for 10 years, with the cumulative increase dedicated to accommodate the expanded mandate;

14.3 that a separate review panel, representing health and academic institutions, health professions, industry, the Health Authorities, the Advocate for a Healthy Alberta, government and the Foundation, be established to deal with these additional areas of research;

14.4 that the findings of these specialized research activities be reported to Alberta Health and the Advocate for a Healthy Alberta for broader dissemination and application throughout the health community; and

14.5 that the expanded operation be effective by April 1, 1991.

Directions for Implementation

Regulations governing the establishment of the terms of reference for the Alberta Heritage Foundation for Medical Research will have to be reviewed and adjusted in 1990 to meet the recommendation regarding timelines for change of name and expansion of activities. Increased budget requirements to accommodate the one per cent for health care research start-up activities can be incorporated in the planning process for fiscal expenditure in 1991/92.

In addition to the activities outlined in the recommendation, the Alberta Heritage Foundation for Health Research should support, encourage, and direct funding to develop and nurture multi-disciplinary health services research units at training institutions. This would serve as a focus for development of critical mass of expertise.

"With the current emphasis on cost-containment, it is essential that we encourage research into alternative forms of health care delivery and to support development of models of care that differ from the current traditional ones."
University of Calgary,
Faculty of Medicine

There is no process currently in place in Alberta where research priorities are set by considering the overall health needs of Albertans. In areas of public health, occupational health, disease, and treatment no priorities have been set. In mental health, the Provincial Mental Health Advisory Council reviews research applications in light of its objectives and does some sorting. Alberta Health is moving toward monitoring and setting priorities for health research. What we need is a review mechanism representing various stakeholders to establish and deal with research projects in order of importance. A panel, similar to the one already in place to establish priorities in the medical research area, should function in much the same capacity with the Foundation.

Most research is published in very specialized journals, or shared at conferences; and interested organizations monitor and sift information from many sources. However, there is very little coordination of these efforts in monitoring, coordinating and communicating the results of the research. Consequently, there is a critical shortage of application of these research findings in practice, particularly outside large health care and academic institutions. Appropriate methods of disseminating the results of research will have to determined, in cooperation with the Advocate for a Healthy Alberta, the Health Authorities, government and other interest groups and organizations, to ensure application throughout the health care community.

"It is recommended that a separate funding mechanism, utilizing Heritage funds, be made available to provide the impetus for public health and epidemiology research."
Health Unit Association of
Alberta

Alberta Health and the local Health Authorities should ensure that research findings are integrated into their policies and plans. Permanent funding should be put into place for new programs, but only after a formal evaluation of each pilot project has been completed.

Individuals and organizations already involved should be encouraged to continue with their investment in bench, basic and applied research, and research in health care. Philanthropic foundations and organizations should continue their support of research and training in health services.

The Alberta Heritage Foundation for Health Research should either develop, or fund, a clearing house for the linkage, indexing, storage, and dissemination of health research data, information, and reports.

Concentrating on good technology

Health technologies can include all procedures, devices, equipment, and drugs used in the maintenance, restoration, and promotion of health. In accordance with this definition, the scope of health technologies needing assessment can be extremely wide and varied. Technology can range from the simplest of homecare products — pregnancy testing kits — and drugs, to the biggest, most sophisticated and expensive equipment — diagnostic imaging scanners.

It is recommended that there is a need to define where to stop with technology with regard to expense.
Grande Prairie Community Townhall Meeting

It is best for assessment and management purposes to define technologies broadly to take into account their interactive, systematic effects. It also should be clear that not all technologies, existing or emerging, can be adequately assessed at any point in time. Accordingly, a mechanism to decide what technologies should be addressed, or a means of setting priorities and limiting the scope of technology studies, must be considered. These assessment criteria must include not just questions of potential dollar benefits or costs, but the effect on quality of life, safety, ethical and other considerations.

Several issues will be involved in determining the scope of health technologies to be assessed. Firstly, attention frequently tends to focus on the "big ticket" items, such as CT scanners and MRI in the imaging field. However, the "little ticket" items like laboratory tests often have a greater impact on hospital or health system budgets because of frequency of use. Secondly, in addition to health care technologies which are integral to conventional health care delivery, a variety of technologies are utilized in health education, health promotion, illness prevention and cure, and in the operation of the health system itself. And thirdly, because health technologies can be interactive and interdependent, the relationship between technologies must be considered. For example, transplant procedures and drug treatment with cyclosporin are inextricably linked. The relationship between technology-embodied capital and manpower must also be considered — safe use of a device is, in part, a function of the skill of the technician.

"It is recommended that, with regard to the necessity to steadily eliminate ineffective or unnecessary programs, we should have a watch dog body to monitor technology and advise funding agencies on the validity of proposed implementations, treatments and investigations."
R.D. Hamm

There has been growing dissatisfaction in recent decades with patterns of noncritical adoption and utilization observed within the health care sector. Existing technologies are generally evaluated before and just after they have been introduced. Without regular or routine evaluation, technology may be inappropriately utilized. In a few cases, technology has tended to emphasize treatment in contrast to prevention. However, the use of technology in prenatal care to determine the likelihood of premature delivery resulting in low birth-weight babies versus the use of technology in neo-natal intensive care treatment of low birth-weight babies born prematurely is a preventive measure that could limit the necessity for treatment. If no useful evaluation is done on the benefits of preventive approaches, but evaluation is done on treatment approaches, then treatment is more likely to be funded, rather than prevention, especially when resources are scarce.

"It is recommended that, with regard to health care, there should be use of technology and the necessity for evaluation of costs and benefits of both existing modalities and new developments, with rejection of ineffective procedures."
P.G. Winkelaar

Technology tends to have high initial and high operating costs, and can rapidly become obsolete. While some technology tends to reduce cost and enhance effectiveness, overall, technology continuously and significantly increases costs in the health system. This is a major concern, particularly due to resource constraints, despite the fact that the real objective of technology is to improve the quality of care.

Health technology assessment could improve the current system by providing information needed to make decisions concerning appropriate acquisition and utilization. New technologies would be introduced for testing and evaluation purposes, and then disseminated for wider application in clinical situations on the basis of the evidence from the earlier rigorous clinical and economic evaluations. This would result in proven health care technologies being acquired according to the ability and willingness to pay, and distributed to appropriate locations according to need.

"Standards and capital funding policies (should) be developed to ensure optimal use of high technology."
Brooks Health Centre

While it is impossible to estimate the overall direct and indirect costs of technological advances in Canada, some researchers have attributed as much as a 3.0 per cent per year increase in net real health costs — on a $46 billion base — to the net effects of technological change. For example, drug expenditures are increasing at about twice the rate of growth of total spending. Utilization increases are putting additional pressure on provincial budgets. Success in determining what the cost of providing health care relative to the Gross National Product (GNP) should be, and then what we should spend will depend, in large measure, on how efficiently health technologies are managed.

Many of the individuals contacted in the course of the Commission's enquiries felt that there should be a clear separation between the "advisory" function and the "paymaster" function. People providing information and advice on health technology issues and planning strategies should not be the same ones paying for the technology.

15.0 **THEREFORE, WE RECOMMEND that the Government of Alberta provide the resources to establish a mechanism to assess health technologies including the scientific, medical/clinical effectiveness, efficiency, and safety; the economic necessity and effectiveness, including direct and indirect costs; and the social and psychological impact, including possible legal and ethical dilemmas;**

15.1 that the mandate of the Alberta Research Council be expanded to coordinate/provide such comprehensive and continuous assessment of technologies, with particular emphasis on health technology;

15.2 that the name of the Council be changed to the Alberta Research and Technology Council to better reflect its role;

15.3 that the Council work in close cooperation with Alberta Health, Alberta Technology, Research and Telecommunications, Alberta Environment, the Alberta Heritage Foundation for Health Research, and the Ethics Centre;

15.4 that the Council serve as the primary contact with other provincial, and national and international governments and bodies to assist in the establishment of international standards and the sharing of technological assessments;

15.5 that the Council develop strategies for both distributing and rejecting technologies, and communicating those actions; and

15.6 that the Council establish, in conjunction with the appropriate private and public sector bodies, the mechanisms to assess and promote Alberta-developed health technologies that may be marketable nationally and internationally.

"It is recommended that the government establish a Technology Advisory Committee composed of expert representatives from the health care/biomedical research fields and health care institutions. This Committee would be responsible for monitoring emerging technologies and arranging for assessment of their potential impact upon the health care system. This Committee would be responsible also for arranging for the assessment of the effectiveness and efficacy of new technologies — through research support — and making recommendations to government concerning the acquisition and placement of new technologies."

Council of Teaching Hospitals of Alberta

Directions for Implementation

It was obvious to the Commission that the framework for the task of assessing health technologies has been pioneered by the Alberta Research Council. The Council is structured into distinct research departments — each linked to a component of the Alberta economy, each with its own clients, and each with a specific mandate and mission. Indeed, some of the current research and assessment activities of the Council are applicable to the health industry. Formal expansion to include health technology as a new department of specialized research should be a priority for the board of directors and the government.

The criteria for health technology assessment should ensure the endorsement of good technology which is:

— least intrusive and most supportive to normal functioning while still most appropriate to the need for which it is to be used;
— necessary, timely, cost-effective and affordable;
— efficient, in freeing health providers' time for use in dealing directly on a personal level with patient needs; and
— widely applicable and conducive to increasing accessibility to health services.

The acquisition of appropriate technologies will have a significant impact on the quality and equity of care. Therefore, transfer of information about technology should become an important part of the assessment process. The results of assessments should be communicated as soon as possible and in an understandable format to Health Authorities and government, as well as the public, media, educators and providers.

The Alberta Research and Technology Council should define its terms of reference or goals regarding health technologies with responsibility to:

— identify and rank new and established medical technologies in need of assessment;
— provide analysis based on scientific findings concerning the value of health technologies from various perspectives outlined in the recommendation;
— compile and distribute information appropriately to the public and the health professions, Health Authorities, government departments and agencies, and other research organizations locally, nationally and internationally;

— present strategies for expediting the introduction of new technologies proven to be effective, for replacing less effective technologies, and for rejecting out-moded and harmful technologies;
— make use of international findings and experience;
— serve as a provincial reference centre for the assessment of health technologies; and
— determine how these functions are to be done, including the contracting-out of services and functions to post-secondary institutions, the private sector, and other organizations.

Alberta Health and the Health Authorities should ensure that the findings of technology assessment are integrated into their policies, plans and programs, and provide funding for new technology only after a comprehensive, favourable assessment has been completed.

New approaches to the funding of high cost technology must be considered. The private sector, as well as the public sector, must be looked to for innovative approaches to funding. A variety of approaches, such as lease-back models and the public utility model, should be seriously considered.

Several companies in Alberta possess the basic capability for health technology transfer and marketing within Canada and for export. More should be encouraged to participate in the health technology field. The international connections and reputation of the Alberta Research Council provide an excellent starting point for expansion in this relatively untapped field of endeavour. As well, the Alberta government should increasingly promote these initiatives through its programs of economic marketing and regulatory assistance.

"It is recommended that discussion and decisions must be made for policies regarding technology and health care."
J. Keating

"It is recommended that Canada establish a systematic, thorough and objective mechanism for the review of new technology to assist in taking advantage of positive advances as quickly as possible, while avoiding ineffective, inefficient and possibly harmful technology."
National Council on Welfare

"It is recommended that improvement of employee morale, restoration of self esteem and team spirit among various categories of health care professionals be viewed as a high priority concern."
Sikh Federation of Edmonton

HEALTH CARE PROVIDERS: HEARTBEAT OF THE SYSTEM

People are the real focus of the health care system — people who need care and people who provide care. Patients and providers are in the process of renegotiating their relationships and the social contract which determines who plays what role in the health and sickness process — a definite shift toward a more democratic, consultative partnership.

During these past two years, the Commission heard from and met with hundreds of Albertans who have the utmost regard for the care they have received from members of the health care professions. These providers are trusted and respected as dedicated, compassionate individuals. We also heard from and met many health care professionals who spoke with warmth and commitment toward their patients, and with enthusiasm for their work. We acknowledge the contribution made by the thousands of Albertans who have chosen careers in the health and health care field.

Nonetheless, the roles of health professionals are being challenged from several directions at once. The challenges arise from the re-evaluation of patients' rights; from the nature of technology innovation and intervention; from other professionals, both from within traditional ranks as well as from alternative practitioners; and from governments. The direction of these challenges involves changes in the approach, scope and emphasis of health professionals.

"Although there has been a shift from infectious to chronic disease there has not been a corresponding shift in our strategy of dealing with health."
Athabasca Health Unit

Challenges and confrontations are not unusual in a climate of change — the struggle to re-adjust, redefine, and evolve toward the appropriate mix of roles to meet emerging health needs creates stress. The challenge to professionals is to recognize that the evolution of a level playing field filled with new players is a natural development occurring across the entire health care system. It is part of the process of health system reform — the movement toward a broader health focus, involving individuals in a more proactive health role. To acknowledge it as a normal part of the health system's growth provides an opportunity for health professions to participate openly in that process. To refuse to recognize that professions are only one aspect of the entire system's growth, and to fail to see their roles as they relate to larger changes taking place in the health care system, can result in viewing the challenges as personal attacks. This leads to protective behaviours and strategies of resistance that place health professionals in reactionary positions rather than in participatory, cooperative and responsive roles.

One of the most frequently cited complaints about health care is that the providers don't seem to exhibit the degree of compassion toward patients or dependence on each other that they did in the past. Increased specialization, technological innovations, getting caught in the rush, and the need to control costs have no doubt contributed to a more depersonalized, detached type of care. Indeed, "the unfortunate upshot of this is that caring has been relegated to a secondary role in medicine. Caring is what you do when you cannot cure." (Dan Callahan, Director, Hastings Centre). Increased emphasis must be placed on the need to prepare practitioners who are not only competent, but compassionate in their attitudes toward their patients and their co-workers.

"It is recommended that the development and understanding of a health care team be an integral part of the training of all speech pathologists, mental health specialists, physiotherapists and occupational therapists."
Public Health Advisory Appeal Board

In addition, a more informed and demanding public expects freedom to choose from among different health care practitioners. Traditionally, the patient's entry into the health care system was determined by a physician. Consumers want to have more information about treatment options, and about the qualifications and competence of health care professionals.

There is conflict, to a lesser or greater degree, between health providers and administrators, among health providers themselves, between the government and both health providers and administrators. Generally, such conflict is dealt with sporadically or at the expiry of a collective agreement. There is too little effort directed toward conflict prevention. Because the concept of human relations has not been a high priority in the system, few avenues to "let off steam" are available. Government is both a player and a law maker.

Current problems in interdisciplinary relationships are based on a large number of complex factors. They include such things as the feeling by certain professionals that their roles are not being adequately recognized and valued. There is an uncertainty about how traditional health professions fit into a new definition of health and health promotion that brings social workers, psychologists, child care workers, environmentalists, media specialists, educators, social planners, and many others into the health picture.

"Human health is influenced by many different factors. It should be seen both as a resource and as something you achieve. The current health care system does not face up to these challenges."
The Alberta Association of Registered Occupational Therapists

Providers within the health and health care system are bound to have a diversity of backgrounds. The concept of most appropriate, least intrusive activity demands that providers effectively complement each other, rather than compete with each other. In the health care setting, teamwork is of the essence. Obviously, we need some individuals with generic knowledge and skills, and others with highly specialized knowledge and skills. To patients, all members of the health care team are important. We accept that team leaders change dependent upon the task and situation needed to return us to a healthier state.

"I have often thought that one of the less attractive traits of various professional bodies and institutions is the deeply ingrained suspicion and outright hostility which can exist towards anything unorthodox or unconventional ...Perhaps we just have to accept it as God's Will that the unorthodox individual is doomed to years of frustration, ridicule and failure in order to act out his role in the scheme of things, until his day arrives and mankind is ready to receive his message..."
The Prince of Wales to the British Medical Association, December, 1982

But there are problems — legislation is one of them. For example, the Medical Profession Act and Regulations prevents referrals to specialist physicians for specialty services from non-physicians and inhibits the ability of physicians to practice together with alternate providers, such as chiropractors and optometrists.

Arbitrators who can look into situations in an unbiased manner fulfill a real need. In our health system, some general mechanisms for averting or resolving areas of conflict are available — between government: binding arbitration; between different providers: the Professions and Occupations Bureau; between unionized providers and hospital administrators: collective bargaining; and between institutionalized mental patients and the institutions: the Mental Health Advocate.

It is worth noting that the Alberta Health Facilities Review Committee currently acts as a resident-patient advocate, and audits the quality of care in long-term care facilities, acute care hospitals, and senior citizens' lodges. Since its establishment in 1973, the Committee has acted on behalf of hundreds of resident-patients, staff, and people who have relatives or friends in these facilities who could not, or would not, deal with management to resolve their concerns.

However, there are only a few such successful examples of dispute resolution, and probably fewer of dispute avoidance mechanisms. The Commission believes that health professionals should be allowed to provide those services for which they have appropriate training and which they are competent to perform. They should also be reimbursed fairly for providing services which fall within their scope of practice, and be rewarded appropriately for their efforts and creativity.

"Nursing and medical education programs should begin to alter their attitude and curriculum to prepare for the coming changes. Professional licensure and accreditation organizations must also adapt."
The Healthcare Company

Matters such as standards, licensing bodies, appropriate education, continuing education, delineation of responsibility, decision-making authority, peer review, adequate numbers of health care providers, and ethical issues need to be addressed.

The Commission sees the emergence of Health Authorities as an opportunity to correct some of the inconsistencies in the system, to re-energize some of the providers, and to redirect some of the resources.

The vision of the health system which the Commission has proposed should be widely distributed and discussed. This will bring about a common understanding, acceptance and commitment toward the role of all concerned in achieving healthy Albertans in a healthy Alberta.

Recognition and rewards

The Commission is of the opinion that a climate needs to be created and nurtured which will attract and retain a wide spectrum of competent, caring and committed providers in sufficient numbers to maintain the level and type of services required. This climate would also manage and minimize conflicts in the health system.

The standard procedure of salary increases, based almost solely on years of service, acts as a disincentive to members of the health professions — primarily nurses. Little or no recognition is given for level of expertise, exceptional performance, or extra effort. Other types of remuneration packages should be considered. Over and above the sense of worth derived from financial rewards, recognizing that various health care providers can make valuable contributions through involvement in decisions regarding services and programs would serve — in itself — as an added morale booster.

> **"...I believe a tiered system is necessary with perhaps substantial pay differentials recognizing that specially trained nurses have specially developed talents...and to keep them, these talents have to be recognized in a pecuniary way..."**
>
> Mrs. Joan Rossall

Institutions of health should serve as role-model facilities in providing safe and healthy work environments for the well-being of staff, patients and visitors.

16.0 **THEREFORE, WE RECOMMEND that the meritorious service, outstanding performance, and development of innovative procedures by those working in the health care system be recognized and rewarded by management;**

16.1 that health care providers be more involved in the decision-making process regarding provision of health programs and services;

16.2 that the various institutions within the health system direct more effort and specific programs and policies toward preventing, managing and resolving conflict between and among the health disciplines, including provision of incentives which encourage good morale, cooperation and teamwork;

16.3 that human resources be maintained in sufficient numbers and with quality knowledge to meet current and future manpower requirements, to respond to the changing needs of patients, and to relieve the stress on overworked, overextended health care providers; and

16.4 that institutions of care ensure that the work environment is safe, secure and healthy, with procedures in place to deal with hazardous or crisis situations.

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ELEVEN COMMANDMENTS
FOR AN
ENTHUSIASTIC HOSPITAL

- Help each other be right — not wrong.
- Look for ways to make new ideas work — not for reasons they won't.
- If in doubt — check it out! Don't make negative assumptions about each other.
- Help each other win and take pride in each other's victories.
- Speak positively about each other and about your hospital at every opportunity.
- Maintain a positive mental attitude no matter what the circumstances.
- Act with initiative and courage as if it all depends on you.
- Do everything with enthusiasm — it's contagious.
- Don't lose faith — never give up.
- Whatever you want — give it away.
- Have fun!

Ian Percy

◆

"I have some suggestions on how to entice the experienced nurses to come back to nursing or to stay with nursing...recognition from management for a job well done, and this does not necessarily need to be as increased pay."
Mrs. Kathryn Kane-Upton, R.N., B.Sc.N

"A working environment in which rewards and recognition are a reality should be facilitated with funding and opportunities for innovative approaches."
Royal Alexandra Hospital

"It is recommended that, costs can be reduced in Hospitals and Medical Care by: allowing nurses to do assessments and teaching presently done unnecessarily by Family Physicians and develop provincial legislation to allow nurses to bill for their services as primary health care givers."
Executive Health Nurses Association of Alberta

Directions for Implementation

The Commission reiterates its suggestions in the Interim Report on Nursing, issued in June, 1988, that "rewards could include merit pay for exceeding job requirements, performance incentives such as paid educational opportunities, career advancement through clinical ladders, and/or other innovative approaches which recognize exceptional efforts."

Various ways to involve health care providers in making decisons should be explored. For example, hospitals should consider the establishment of clinical administration services (CASs). The principle of returning authority to the local level that we recommend in establishing regional Health Authorities could be applied in hospitals — allowing ward, unit, or service control over their own operating budget for services provided. This structure would encourage cooperation of all workers in a given service, enhance team spirit, build morale, and hopefully decrease staff turnover. This process would involve nurses and physicians in necessary administration and decision-making duties, and decrease irrelevant regulations and rules. This should result in increased efficiency and effectiveness of patient care. To the patient this means better, more individualized care. To the providers this means more flexibility and accountability regarding services and resources.

Hospital management has an obligation toward all members of the health care team to attempt to reduce stress and stressful situations. The Interim Report on Nursing (see Part Six on page 185) made a number of recommendations and observations regarding working conditions and relationships. These should be reviewed by hospitals and Health Authorities and acted upon if they have not already done so.

Recognizing the importance of conflict prevention, increased training should be provided in conflict prevention and management throughout the system — in all care facilities, within professional associations, and as part of educational programming. In so doing, the following principles, should be understood:

— Conflicts are a mix of procedures, relationships, and substance.
— To find a good solution, you must understand the problem.
— Plan a strategy and follow it through.
— Progress demands good working relationships.
— Agree on a constructive definition of the problem.
— All parties help design the process and solutions.
— Lasting solutions are based on interests, not positions.
— The process must be flexible.
— Think through what may go wrong.
— Do no harm.

(Managing Public Disputes: Carpenter, S.L. and Kennedy, W.J.D.; Jossey-Bass Publishers)

While the Commission is optimistic that there will be improvement in the health system environment as providers adapt to change and authority is redirected, we recognize that this will take time and that problems may arise in the interim. Therefore, the government should seriously reconsider permitting groups to withdraw services — but only after meaningful attempts at mediation, conciliation, and arbitration have failed, and only where essential services will continue to be provided through predetermined, binding agreement by the providers with their respective Health Authority Boards.

"Employees must have some type of leverage in making their demands as employers have all the leverage and therefore control of the situation currently. (Example nurses must have the right to strike)."
Staff Nurses Association of Alberta

Teaching teamwork

The attitudes and relationships of health care personnel, working together cooperatively with strong linkages, are vital to successful delivery of services and programs. The Commission believes that the goal of health-professions education should be to prepare practitioners who will be competent to provide care and who will exhibit caring attitudes toward patients. Practitioners must be knowledgeable about the systems in which they work, and must be willing to initiate changes to make the systems operate for the comfort and well-being of patients.

"Attitude and philosophy are two main factors in having a happy, efficient and productive staff, and this emanates from the top down in the form of leadership. If those in positions of authority demonstrate that they care with actions rather than words, then the masses will follow. Otherwise, the attitude 'Who cares?' prevails and everyone loses, including the taxpayer."
Gary McPherson

The diversity of health providers could result in increasing disputes over practice boundaries among and within professions. Such disagreements arise periodically among the various professions and within specialties of particular professions. Some health care providers contend that constraints imposed by other professions, and various rules and regulations, unfairly prevent them from providing services for which they feel they are qualified.

Four factors have been critical in the development of boundaries of practice: professional licensure, voluntary certification programs, health care facility rules delineating clinical privileges, and health care insurance coverage restrictions.

It is conceivable that problems relating to boundaries of practice will continue to exist because of the increasing number and types of health care providers, and the growing complexity of health-professions education. In some cases, there is an overlap in training, qualifications, and functions of health professionals. The problem is further aggravated by the increasing number of specialties within health care professional groups, and by lack of sufficient contact and coordination between the various educational programs for health professionals. Competition among health care providers — together with the desire of health care practitioners for increased training, enhanced prestige, and greater financial reward — creates the potential for continuing jurisdictional disputes among and within professions.

"I would like to see mechanisms introduced to encourage better communication among the entire health care system — nurses, physicians and others, giving them opportunities to address controversial issues in a co-operative and constructive manner."
Mrs. Judith Goldsand

"(It is recommended that) post secondary educational institutions be funded to provide bioethics instruction in all of the health sciences programs."
University of Alberta

"...it is not the equipment, the library, the numbers of staff which are most important but how these things/people work together to produce results which are beneficial to the patient."
Dr. Leslie Hardy

"It is recommended that doctors be educated in medical school to see the value of the team approach and appreciate the skills of other health providers."
Grande Prairie Community Townhall Meeting

"It is recommended that the theory and practice of ethical decision-making be a component in the educational programs of all health care professionals."
Catholic Health Association of Alberta Catholic Hospitals Foundation of Alberta

The Commission is convinced that ethical issues will face members of the health care professions with increasing frequency. Difficult decisions — involving questions of life and death — have always created dilemmas to providers, but changing technologies and more patient control will complicate these matters further. Formal courses to help health care providers deal more effectively with their own conflicts and the information they are obliged to give their patients should be required studies in all health-disciplines programs.

17.0 **THEREFORE, WE RECOMMEND that course content emphasize relationships and roles of different members of the health care professions in areas of common concern and practice, focus on the complementary nature of the professions, and provide instruction in conflict and stress management;**

17.1 that ways be developed within and among post-secondary institutions and among instructors of health care providers to ensure that the interdependence of the professions is being reinforced at all levels; and

17.2 that Alberta Advanced Education provide course development funds, and that appropriate faculties re-allocate their resources, to offer by 1993, ethics courses to all students enrolled in health-disciplines programs.

Directions for Implementation

Concerted efforts must be made to reinforce the interdependence between professions, to break down distrust between professional groups, and to help them to understand and appreciate each other's roles. Such understanding must start early and be basic to the education and training of health care providers. In addition to the technical aspects of their programs, students should be made more aware of some situations which may be peculiar to their working environment.

Discussions on improving interdisciplinary relations, conflict management among professions, and team-building are not the focus of any formal health courses in Alberta's post-secondary institutions. These topics are sometimes discussed as part of the courses in health services administration, community medicine, and trends and issues in nursing programs. Such efforts should be expanded to all programs. Implementation would be assured through an interdisciplinary, inter-institutional committee of instructors involved in the development of appropriate course outlines to assist all teachers. The committee itself and instructors within institutions would become examples of complementary and interdependent professions.

The Ethics Centre should assist in the development of the ethics courses, and the provision of instructors, lecturers and resource materials to post-secondary institutions involved in health-disciplines programs.

Filling the manpower gaps

A human resource consultative process to more accurately identify province-wide health manpower needs and plan training programs has to be developed. The process should incorporate the notion of appropriate and efficient skill utilization to ensure service delivery in each of the regional Health Authorities. An efficient health care system would recognize the interdependence of the health professions within and among the regions and other provinces, and maximize the use of allied health professions while maintaining and improving the quality of care delivered for Albertans.

Careful monitoring of trends in health manpower is required to assure the human resources required to meet the current and future needs of Albertans. An integrated health manpower policy, derived from the current and anticipated needs of Albertans, and based on providing a complementary range of services in a wide range of settings is required. Health Authorities should consider this identification process an ongoing priority so governments and post-secondary institutions can respond with training and education programs in areas where sufficient manpower shortages exist.

There is, through the Health and Social Services Disciplines Committee, a formal system in place which tries to anticipate changing health manpower requirements and signals the need for change. But, because of the controversial and complex nature of such manpower information, their findings are often disputed. When they project shortages, it is difficult to introduce measures to correct the problem in a timely and coordinated manner. There needs to be increased cooperation between the suppliers of health manpower and those needing health manpower, in order to have a coordinated, smoothly running system.

Part of the difficulty with planning results from overlapping areas of responsibility among some health disciplines, a certain degree of self-interest on the part of stakeholder groups, and competing interests among educational institutions, teaching hospitals, and professional associations. These problems may be complicated by demographic changes and economic fluctuations, and influenced by advancements in technologies. Various groups take different stands on the need for training programs, education standards, and optimum numbers of personnel. Consensus on the statistical interpretation of currently available manpower data in any field can be difficult to achieve at a regional and provincial level — and more so within western Canada and across the country.

"It is recommended that the Department of Health, together with the Departments of Advanced Education and Labour and various professional societies develop appropriate manpower planning techniques to assure a continuing supply of well trained professionals and technologists for Alberta's health care field."

Foothills Provincial General Hospital

"The problem is further exacerbated by the fact that the service boundaries of these various health care deliverers overlap in many instances and cause jurisdictional disputes. This leads to duplication of services in some cases and, conversely, the lack of provision or the partial provision of services in other cases where more than one department has overlapping responsibilities.

...health care providers tend to be very territorial and would perceive any attempt at rationalization as an encroachment upon their 'turf'."

Mr. L.V. Hough

"Guidelines should be established regarding staffing in order that the most cost efficient and effective means of health care is provided. It is not necessary that the most highly trained staff is doing work not requiring professional judgment."
Alberta Association of Registered Nursing Assistants

The rate at which knowledge is expanding makes the maintenance of professional competence a matter of concern. Health professionals must ensure that the best possible care is being provided to patients, and the public needs assurance that health professionals can and do maintain competence throughout their careers. Providers have an obligation to participate in continuing education programs which are designed to meet changes in the field of health care delivery.

18.0 THEREFORE, WE RECOMMEND that the health manpower needs of the Health Authorities be reviewed following the identification of their local priorities to ensure sufficient numbers of providers of the required mix are being attracted to and trained in the appropriate health disciplines;

18.1 that post-secondary institutions in Alberta be apprised of emerging trends and needs so they can respond promptly with relevant training and retraining programs, and continuing education courses;

18.2 that Alberta work cooperatively with other jurisdictions to improve mechanisms to identify health manpower needs and coordinate appropriate training and educational opportunities throughout Canada, but particularly within the western provinces; and

18.3 that Alberta continue and expand its purchase of seats at out-of-province post-secondary institutions to train people in priority programs of study not available or at full capacity in this province.

Directions for Implementation

Current manpower planning efforts must be streamlined and substantiated, and prepared on the basis of the boundaries of the Health Authorities, taking into account the changing health needs of Albertans and complementary health care delivery services.

"It is recommended that the informal cooperation that goes on within the hospital system should be encouraged in every way possible."
H.L. Morrison

Cooperation between and among professional groups in identifying and projecting future manpower needs, and in articulating professional roles and responsibilities that will foster partnerships in care delivery is essential. A greater degree of collaboration between health care administrators and educators, and between provinces, in defining the nature and output of educational programs to facilitate manpower needs is imperative.

The ability and flexibility to phase up or down the various manpower categories, including physicians, should exist as needs develop or decline. This relates to both entry-level preparation programs as well as programs for retraining of personnel.

More funding and computerized equipment may be necessary for collecting, analyzing, and synthesizing health manpower data to ensure that comprehensive and current information in a consistent format is widely available for manpower planning. Such future plans should give consideration to the incorporation of manpower substitutes — nurse practitioners, midwives, dental therapists — into specific areas of service delivery where this is shown to provide a cost effective, high quality alternative for provision of care. The data should relate to manpower demand, supply, and distribution by profession and by specialties within professions. This should assist in bringing about a workable consensus on manpower issues.

Professional schools and health professions should develop and update continuing education self-assessment programs, prepare guides to continuing education programs to be taken by health care providers throughout their careers, and attempt to ensure that acceptable programs of continuing education are available to providers to ensure high quality service.

Alberta should build on its capability to deliver programs through distance learning initiatives to ensure that the maximum number of health care providers in the greatest number of locations are being reached.

Additionally, comprehensive networks should be put into place so health care practitioners could have immediate telecommunication or telesatellite access to specialized consultation services and health information. This could limit the need for patients to travel to the urban specialty and referral centres for assessment by specialists. Such networks would not only improve the efficiency of the system by reducing crowding in urban centres, but improve the knowledge and dignity of communities and rural health practitioners.

Manpower planning for Alberta cannot be done in isolation. The extent of interprovincial migration of professionals indicates a need for interprovincial coordination. Furthermore, international movement of professionals supports the need for a federal-provincial approach.

The current arrangements among the provinces to purchase seats in certain post-secondary health programs which are not offered in the home province should be expanded to include those programs which may be at capacity levels in one province but not in another.

"It is recommended that there be open referral, so different practitioners can begin to assess the efficacy of each other's therapy for particular complaints."
A. Chan

"Continuing education must be provided for all dental professionals to increase their awareness of advances in the treatment of oral diseases."
The Alberta Dental Association

"It is recommended that there be an audio visual connection for hospitals that would provide a link so that smaller centres can take advantage of the in-house training available to the staff of larger hospitals."
Tim Morrison, Gordon Pincock

"It is recommended that there is a need for coordination and interprovincial planning of all health care human resources."
National Council on Welfare

AN IMPORTANT PERSPECTIVE

People must always remain at the forefront of the decisions, changes and adjustments we make to provide health and health care services to Albertans. We have explored in detail the concepts of all of us and some of us, and how we can best relate our health needs to the components of the health care system. The Commission has set general directions for us to better understand how we are, and how we can achieve healthier lifestyles through knowledge and awareness. The groundwork has been laid to give individuals greater control over decisions which affect them directly in matters of health and health care. While maintaining the principles of universality and access to health care services and providers, the door to options and alternatives has been opened.

Major changes have been recommended in the management and administration of health care services, programs and facilities so that the system can be more responsive and relevant to the people for whom it was originally intended. We recognize that we face both an opportunity and a challenge regarding advancing technologies. Their capacity as information and communication tools will result in improved efficiencies and better medical and health management practices. We anticipate increasing resolution of conflicts in the health care domain as practitioners realign their commitment to each other and their patients.

None of the directions the Commission has outlined are beyond the reach or realm of possibility. Their successful implementation is dependent on commitment to developing healthy public policies which focus on individuals — both providers and consumers.

However, matters directed toward improving health and health care are fully effective only as they fit within the much larger picture. Without a quality environment, our quality of life will be non-existent. The ideal future is one which recognizes the inter-relationship between our personal health behaviours and our global environmental health practices. As we stated in the introduction to this volume — *nothing matters if we can't breathe.*

CHAPTER FOUR

THE WORLD AROUND US

CHANGING ATTITUDES

The mention of "sunny Alberta" conjures up a picture of clear, blue skies ...sparkling, pristine lakes, streams and rivers ...rich, black soil...blowing wheat fields...endless northern forests...rolling hills and majestic mountains. Well-ordered cities and towns...rural communities and remote homesteads...responsible and planned growth and economic diversification.

The Earth is 4.6 billion years old. Such a timespan is inconceivable but can be likened to a person who is 46 years of age. On that basis, modern man has been around for four hours. The industrial revolution started a minute ago, but in that minute the planet has become a junk yard.
Time, November 27, 1989

Concern for environmental health is an issue in which the public leads our politicians.
Science Council of Canada

"There is an increased public awareness of environmental hazards to health and future generations. It is no longer adequate to make decisions in isolation based upon economic gain."
Wetoka Health Unit Board

"We cannot sustain the way we have been living for the last 40 years. Our planet cannot sustain the cost to its systems: our population cannot sustain the monetary costs and our society cannot sustain the moral costs."
E. Maroes

The Indians say "we do not inherit the land from our grandparents, we borrow it from our children". Will future generations be able to conjure up the same clean, clear picture? Will Alberta be able to maintain an environment that is suited to efficient development, to preservation of health and comfort, and to enjoyment of living today and in the future?

Or will Alberta fall victim to industry-based growth, individual indulgence, and global environmental destruction?

Environmental health involves those issues where community health can be enhanced through the improvement of the quality of the human environment by identifying, assessing and controlling the health-related contaminants in air, water, land and the food chain.

Pollution of our environment is seen as one of the greatest threats to humanity. Concern for current and future health has become paramount in the minds of Canadians. This is a decided shift — from traditional conservation aspects related to wildlife and recreational impacts — toward personal well-being. Most of us believe we have already suffered adversely from some form of pollution, and that the worst is yet to come...that more hazardous discoveries are being made practically each day...that life-threatening accidents occur around the world or around the corner with greater and greater frequency. Yet, despite much talk, frighteningly few actions are being taken to effect the kinds of changes that are needed.

Albertans have, as have most Canadians, become more aware of the environment as a health issue...largely due to media coverage of the high-risk, long-term effects of well-publicized technological accidents like Chernobyl and Bhopal; and the apparent low-risk, short-term effects of chemical spills from transport vehicles on roadways throughout the province. Additionally, we are aware of the risk of exposure to toxic wastes and low-level radiation; of additives to our food, fuel and cosmetics. We must determine whether containers, products and materials are recyclable, biodegradable or non-aerosol. We hear about the hole in the ozone layer, the global warming caused by the greenhouse effect, and mass destruction of the rain forests. This increased awareness has spawned both concern and confusion regarding causes, regulatory measures and responsibilities.

The notion that we are safe, protected or immune to such dangers is a thing of the past...that we might influence, affect or control decisions is the wave of the future. In fact, people are prepared to make personal sacrifices to achieve environmental protection. A 1989 survey of people from 14 developed and developing countries, conducted by the Harris Poll and sponsored by the United Nations and the World Bank, showed resounding support from 90 per cent of the respondents to paying higher taxes and accepting, if necessary, a lower standard of living to reduce environmental degradation and ensure protection.

A concerned public is not a complacent public. In our own best interests — and those of future generations — we will expect and demand that health considerations be placed on an equal footing with other consequences of economic development and progress.

All of us are in this together

The problems of the environment are as big as the world itself. No longer can we as Albertans and Canadians put the responsibility for "our" environmental crises onto other countries, onto the laps of politicians and government regulators, or onto the backs of business and industry. All of us — individuals, corporations, environmentalists, governments, organizations — are stakeholders in the world around us. Learning to work together in confidence and trust is the first hurdle we must overcome.

What is our commitment as individuals? Answering a public opinion poll is one thing — actually paying higher taxes to clean up or protect the environment is another; changing behaviour is still another.

In rich countries, a new breed of green consumers appear prepared to pay premium prices, if necessary, for products which claim to be kind to the earth. Food processors and other manufacturers are beginning to recognize the double bonus — profit and an improved corporate image — in the idea of "going green" to woo consumers. We seem to be making some progress toward becoming more responsible consumers by changing our purchasing habits. But it is more difficult to change our habit with garbage — the real issue.

The average Canadian household produces 20 to 40 litres of toxic waste each year — the largest single class of hazardous waste generation in Canada. (*Connexions*, Winter 1989) A four-person household probably produces at least 3.5 tonnes of trash annually. Small wonder that a radio commercial — advertising laundry detergent refills in new, near-biodegradable plastic bags — begins by suggesting that it would take garbage trucks, lined up bumper-to-bumper from St. John's, Newfoundland, to Vancouver, British Columbia, to hold one-year's worth of Canadian domestic garbage.

The Government of Alberta is committed to providing a clean, safe environment for Albertans. In 1971, it was the first government in Canada to establish a department of the Environment, and now spends more per capita than any other province — $90 per person or $119 million in total for 1989-90. The province has identified the need for leadership, responsible policies, research initiatives, and conservation strategies by all stakeholders in an effort to balance economic and environmental concerns. However, health per se, as part of environmental concerns, is not yet on the agenda for debate.

"As Alberta grows more urban, so too grows the risk that we will lose touch with nature. Without knowledge or emotion relating to the outdoors, a sense of commitment and loyalty to it is lost. To value the natural world, we must maintain meaningful contact with it."

Alberta Recreation and Parks

"To achieve the protection, improvement and wise use of Alberta's environment now and in the future."

Alberta Environment's mission statement

The Environmental Council of Alberta has been developing a conservation strategy for Alberta through public consultation. In response to a 1986 initiative developed by the National Task Force on the Environment and the Economy, Alberta announced that it will establish a roundtable to create a consultation forum represented by all stakeholder groups to formulate strategies that will achieve a balance between economic and environmental concerns. New legislation regarding environmental enhancement is being drafted and public input is being sought.

For years, industry — considered the culprit — was shut out of the environmental arena. Only recently — when they joined discussions on the United Nations World Commission on Environment and Development three years ago — has their potential as a positive contributor been acknowledged.

That World Commission opened doors for industry to participate in a proactive and constructive fashion, challenging industry in a way which has allowed them to respond. Industry is now invited to attend conferences and roundtable discussions as an equal partner.

This new cooperative approach is starting to achieve results. Inco, Canada's number one polluter, is in the process of spending $500 million of its own to cut sulphur dioxide (SO_2) emissions from its Sudbury smelter. The 1982 sour gas blowout at Lodgepole, Alberta resulted not only in stricter regulations and high costs for drilling sour gas, it was the catalyst for the Canadian Petroleum Association to set out its own environmental codes of practice. Industry set out to demonstrate to the government and the public that it could regulate its own members effectively and consistently.

There is a need to encourage business to look for new, clean technologies. Currently, with our emphasis on regulation rather than incentive, industry tends to focus on clean-up technology rather than clean technology.

"If industry causes a health problem, that industry must help to control or cure the problem.

It is recommended that contamination of soil, water and air by industry that effects us all, needs to be dealt with in a positive, helpful and meaningful way."
M. Peplar

The Greening of the Boardroom

As Inco's Executive Vice-President, Roy Aitken says, "Ten years ago most businessmen thought of the environment as a nuisance. Now it's more like a national crusade."

The old environmentalists believed all growth was dangerous. Industry didn't buy it. New environmentalists talk about "Sustainable development", a philosophy which reconciles growth with protecting nature.

During the course of this century, industry has been forced to accept the fact that it has a moral and legal duty to incorporate certain social costs into its cost of doing business.
Robert Collison, Report on Business Magazine, July 1989

Most of us have recognized the problem of natural resource depletion. Now we need to institute policies that reward investments that meet sustainability criteria to protect the environment while using resources wisely. According to the World Bank, cost benefit analysis must take into account evaluation of waste treatment and waste disposal as part of the full cost of doing business. Clean technology that avoids producing the waste in the first place is the most sustainable. Indeed, a model piece of U.S. legislation, a spin-off of the Love Canal hazardous waste disaster, requires chemical and petroleum industries to pay a tax to establish the Superfund Program so that the possible cost of clean-up becomes part of the cost of doing business. The costs are, therefore, recognized in the executive suite — and by shareholders — in a pro-active rather than a reactive way.

Environmentalists, once considered a radical, fringe group, are gaining acceptability in the boardrooms of industry, on government planning and regulatory bodies, in universities, and most recently as regular media contributors.

Environmental lobby groups have changed from focusing on large global issues to matters closer to home. In Alberta, there are a number of groups dedicated to water, forest and land protection, health impact, and recycling. More and more people are thinking globally and acting locally.

These groups not only educate the public but lobby government about environmental issues. One of the best examples of cooperative effort is the quarterly, *Environment Views*, published and funded by Alberta Environment but produced through an independent editorial board with representation from environmental groups, government and industry.

THE NOT-SO-PRETTY GLOBAL PICTURE

There are three major threats to the global environment and our personal health: depletion of the ozone layer, global warming, and resource depletion. These issues concern all of us — all over the world regardless of international boundaries. Some of us are in a more critical position than others, while some of us are in the fortunate position of being able to learn from the experiences of others.

Knowingly and unknowingly, we have managed to put our air and water supplies in grave jeopardy. As developing countries increase their economic activity and raise their standards of living, they too will become heavy users of these dwindling resources.

It is important to understand what the major threats to the global environment — and, therefore, to our very existence — are, and that they are inter-linked.

The Ontario Law Reform Commission is urging significant changes to give public-interest groups greater access to the courts to fight for environmental causes.

One of the key changes recommended would allow individuals and groups the right to gain standing before the courts in order to raise issues of public interest.
The Globe and Mail,
Tuesday, Oct. 3, 1989

"An education in ecological responsibility is urgent: responsibility for oneself, for others, and for the earth.

...true education in responsibility entails a genuine conversion in ways of thought and behaviour. Churches and religious bodies, non-governmental and governmental organizations, indeed all members of society, have a precise role to play in such education. The first educator, however, is the family, where the child learns to respect his neighbour and to love nature."
Vatican Speech
World Day of Peace
Jan. 1, 1990

"It is recommended that there should be incentives to industry to use products which do not destroy the ozone layer."
J. Neuman

Depletion of the ozone layer

About 90 per cent of the Earth's ozone is found naturally in a layer 15 to 35 kilometres above the Earth's surface. This ozone layer protects life from the sun's deadly ultraviolet rays by absorbing them. But it is being damaged — holes are being ripped in it by toxic chemicals that are emitted into the air, rise and get trapped in our ozone blanket.

The biggest threat to the ozone layer is chlorofluorocarbons (CFCs) — such as refrigerants, aerosol propellants, and the bubbles in foam cushions, insulating foam, and polystyrene plastic containers and packaging. Released into the atmosphere, such chemicals thin the ozone layer, causing it to lose its ability to filter out and protect us from excessive ultraviolet radiation from the sun. Without that natural protection, we will fall victim to dramatically more incidents of skin cancers, cataracts and other medical problems. People are becoming increasingly aware of CFCs, and many of us are adjusting buying habits to reflect our concern.

People are becoming increasingly aware of CFCs, and many are adjusting buying habits to reflect their concern.

Health impact

In September 1987, *Environment Views* reported that "the (United States) Environmental Protection Agency's studies estimate that if the ozone layer is destroyed on an average increase of 2.5 per cent per year, people born between 1985 and 2029 could suffer an additional 8.3 million cases of skin cancer resulting in an additional 167,000 deaths. For people born between 2030 and 2074, the EPA statistics are even more horrifying — an extra 30 million cases of skin cancer, including lethal melanomas, will result in an additional 620,000 deaths."

"The greenhouse effect, depletion of the ozone protection, continuing pollution, and the end products of changing and increasing health problems must be considered and planned for, for future health care to be effective."
G.C. Stirling

What are we doing about it?

In 1987, 24 countries signed the Montreal Protocol setting a target for 50 per cent reduction of CFCs by 1999. This has been accelerated by Canada, the United States and the European Economic Communities to a bolder target of 100 per cent reduction by 2000. This is a formidable task with only a 10-year time-frame for accomplishment. Restricting production is one thing, but convincing consumers to give up the comfort of their foam cushions may be more difficult to achieve, and near impossible to enforce. Viable alternatives must be sought.

These good intentions and positive actions could be wiped out by the challenge presented by China, India, South Korea, Indonesia and Brazil who plan to increase CFC production during the next 10 years.

Global warming

Source: Environment Views, Vol. II, #3, Dec. 1988

The planet's temperature is higher than it has been since statisticians began to keep records. In the next 50 to 60 years temperatures may increase by another two to four degrees. The rate of change is likely to increase dramatically during the 1990s.

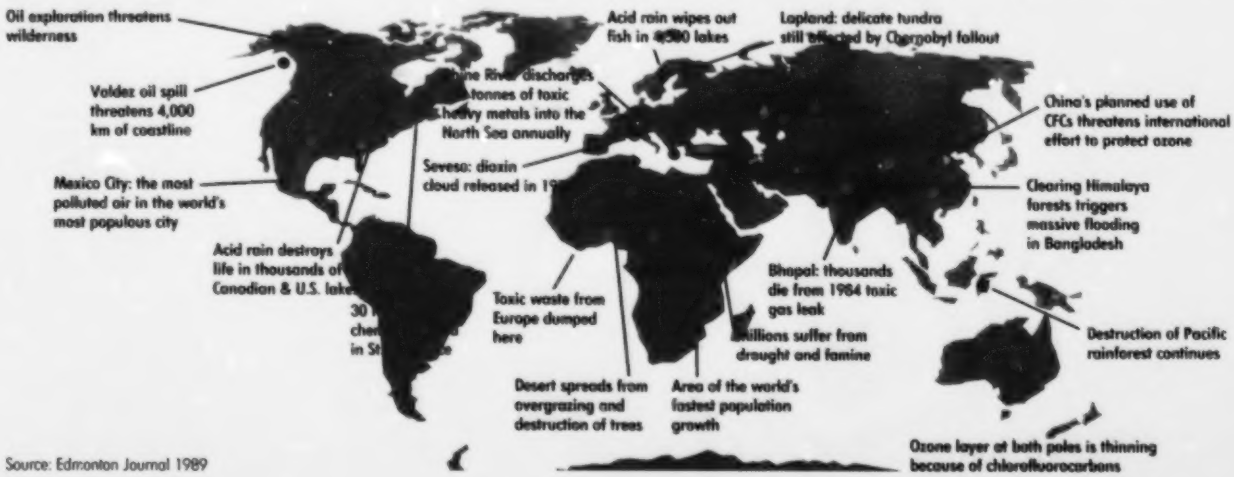
As solar energy enters the atmosphere, light is absorbed by the earth. It is re-radiated at longer heat wavelengths, some of which are captured by greenhouse gases — such as carbon dioxide, CFCs, methane, and nitrous oxide. Higher concentrations of greenhouse gases trap more re-radiated heat. When atmospheric and surface temperatures increase, weather and climate patterns change.

What we know today about heat trapping of gases was basically spelled out to us 100 years ago. We know that carbon dioxide and other gases can let sunlight through easily and trap heat near the surface. We also know that we've increased carbon dioxide by 25 per cent in the past 200 years, and doubled the incidence of potentially harmful gases like methane and nitrous oxides, and added CFCs which never existed before.

Scientists say this global warming trend is the direct result of human activity that increases the levels of carbon, carbon dioxide, methane, and CFCs in the atmosphere, through industrialization.

CFCs are most easily traced, but this is not the case with two other greenhouse gases — methane probably comes from rotting waste, raw sewage, and leaking natural gas; while nitrous oxide comes partly from internal combustion engines, coal-fired power stations, fertilizers, and land clearing. Carbon dioxide emissions result from the burning of fossil fuels, wood, coal, oil, and natural gas. The impact of these emissions has increased because of deforestation. Forests are the lungs of our planet — normally converting 10 to 30 per cent of annual carbon dioxide emissions from humans into oxygen. It is estimated that the burning of oil, gas and coal releases carbon into the atmosphere as gaseous $C0_2$ at about five billion tonnes per year — equivalent to 10 000 tonnes per minute — non-stop!

ECOLOGICAL HOT SPOTS AROUND THE WORLD


Oil exploration threatens wilderness
Valdez oil spill threatens 4,000 km of coastline
Mexico City: the most polluted air in the world's most populous city
Acid rain destroys life in thousands of Canadian & U.S. lake
30
che
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ine River discharges
tonnes of toxic
heavy metals into the North Sea annually
Seveso: dioxin cloud released in 19
Acid rain wipes out fish in 4500 lakes
Lapland: delicate tundra still affected by Chernobyl fallout
China's planned use of CFCs threatens international effort to protect ozone
Clearing Himalaya forests triggers massive flooding in Bangladesh
Bhopal: thousands die from 1984 toxic gas leak
Toxic waste from Europe dumped here
illions suffer from drought and famine
Destruction of Pacific rainforest continues
Desert spreads from overgrazing and destruction of trees
Area of the world's fastest population growth
Ozone layer at both poles is thinning because of chlorofluorocarbons

Source: Edmonton Journal 1989

"What people have to remember is that the bottom line is every year we add ninety million more people to the planet. That is the equivalent of more than the population equivalent of another U.S. every three years."
Stanford University ecologist, Paul Erlich

Health impact

The impact of global warming on health relates to our ability to feed ourselves. According to one study in 1986 by the Council of Scientific Unions, a one-degree increase in temperature with an accompanying 10 per cent decrease in rainfall leads to a 25 per cent decrease in grain production. Global warming leads to climate change and loss of top soil. Add over-population and you have, literally, a deadly mix. More than five billion people inhabit the earth now — and our numbers are growing by 275 million every three years. One-quarter of us currently uses three-quarters of our arable land and biological and mineral reserves. It isn't hard to calculate that we will soon be in the middle of that deadly mix as Third World countries try to emulate our affluence.

What are we doing about it?

Because global warming results from the accumulation of airborne pollutants above the earth, it will require a major effort on a number of fronts — reducing the pollutants; maintaining the environment's ability to cleanse itself; protecting our diminishing resources; finding alternatives to fossil fuel energy sources; and decreasing the world's population growth. In the future, black gold will be our precious topsoil.

In the future, black gold will be our precious topsoil.

Since the major pollutant is carbon dioxide, any changes will have to involve a serious reconsideration of our reliance on fossil fuels. This is occurring both through conservation efforts and research into alternate sources of energy which hopefully will be less lethal.

The automobile is a major polluter — the car produces 60 per cent of our total lead emissions, 20 per cent of our nitrogen oxide, and 45 per cent of our carbon monoxide. Amazingly, close to 95 per cent of the people of the world do not own cars! The 1988 "Changing Atmosphere Conference" held in Toronto targeted a 20 per cent reduction of CO_2 emissions by the year 2005, and a 50 per cent reduction by 2050.

LEAD EMISSIONS FROM CARS: Each year 450,000 tonnes of lead are released into the air by humans, compared with 3,500 tonnes from natural sources. Lead from vehicle exhaust represents more than half of this pollution. Lead is added to petrol to improve its combustion properties, and is released to the air as fine particles.

Resource depletion

The threatened loss of the Amazon and British Columbia rain forests is akin to a "lung amputation" for Mother Earth. Massive public concern is leading to reappraisal of economic policies that initiated the destruction in the first place, and causing governments to proceed with development in a more cautious manner.

More than half of Alberta — 360 000 square kilometres — is covered by forests. Of the total forest area, 196 000 square kilometres are classified as timbered deciduous and coniferous forest land. The government, in its attempts to diversify the economy, has issued Forestry Management Agreements on 93 000 square kilometres of Crown timberlands. There are differing opinions about the wisdom of this decision, but the government maintains that less than half of those lands will be cut since a proportion of management areas is designated for recreational and wildlife purposes. Public hearings provide the opportunity for the various interest groups to present their positions, and for government to defend its decisions.

The rape of our top soil is less noticeable than in Africa where every year thousands of hectares become deserts that cannot be retrieved. Could Alberta become a Sahara of the future? It shouldn't happen — but we must recognize that subtle depletion through overuse of chemicals, leeching through over-irrigation, and over-working the soil could lead to the same end. The importance is to ensure sustainable growth and responsible practices, a balance between growth today and growth tomorrow.

"The roads and the home environment are encroaching on one another to an extent that they are causing health problems for our children and the elderly especially."
M. Barker

"It is recommended that the only possible way to achieve a "Health Care" system that delivers what its name promises is to place as our foremost objective a clean environment."
B. Smith

Health impact

Who is to know precisely the impact of the environment on our health? Indeed, it is not possible to separate the two — we cannot sustain our health if we do not sustain our environment. Improperly addressed, a variety of environmental concerns will have a major impact on our health, individually and collectively. Our well-being, our way of life, our standard of living — our very existence — will be threatened. To ignore reality and refuse to adapt would cause us to be trapped, dinosaur-like, in a situation from which there is no escape.

But we do adapt. We do change what, how and why we do the things we do. Ten years ago, we wouldn't have held much hope for nuclear disarmament ...glasnost meant nothing to us...CFCs were considered safe. Times change, pressures mount. Measures will be taken to ensure the protection of our environment and our health — because we will help, we will insist.

What are we doing about it?

While we can talk about conservation, few of us want to conserve to the point where it means cutting back on either our personal lifestyles or economic growth.

Conservation or cutbacks may not be realistic in a world where developing countries have a lot of catching up to do to reach even our minimum standards of wealth. A more realistic alternative may be to find ways to use resources more effectively and efficiently, and to find alternate sources that are easier to manage.

There has been a growing interest in alternate forms of energy. Our primary powers of energy, for the most part, are non-renewable: natural gas, oil, coal and conventional nuclear power. Alternate renewable sources include wood, plants, dung, falling water, geothermal sources, solar and tidal wave energy — plus human and animal muscle-power. Nuclear reactors that produce their own fuel and, eventually, fusion reactors also are in this category. (*Our Common Future,* 1987)

A few Canadian companies are successfully selling wind and solar energy generating systems. These energy systems offer alternatives to those sources of energy that adversely affect the environment. Some companies are marketing energy systems capable of harnessing sunlight for purposes of ventilation, and household water and air heating. Scientific breakthroughs have occurred in Britain, the United States and Australia in designing efficient methods of turning the sun's rays into electricity. Canada is on the fringe of such research, however, funding is required to advance research abilities.

In the past six years, more than 20,000 Canadian vehicles have been converted to operate on natural gas. In that time, 114 public natural gas fueling stations have been opened. As well, vehicle conversions to methanol could expand markets for Alberta's growing petrochemical industry. Electrically powered vehicles are also a consideration.

Such alternate approaches are possible but each may pose its own health risks. For example, emissions from natural gas, considered the cleanest of the hydrocarbon fuels, and methanol powered cars could interact with existing pollution to cause serious health risks. We just don't know. Nonetheless, these alternatives must be explored…risk must be balanced with careful study and quick action should unsafe conditions be identified.

Janson Edworthy of Nor-Wester Energy Systems of Calgary feels wind power would be more widely used if utilities were forced to charge their customers to pay for the environmental damage caused by burning coal, natural gas, or oil. Building a modest 10 megawatt "wind farm" to replace the equivalent coal burning generation would eliminate 23 million kilograms of pollutants a year, e.g. acid-rain causing sulphur dioxide and carbon dioxide.

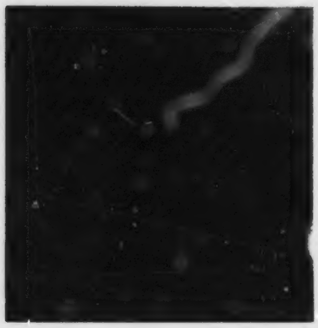
Financial Post, Oct. 20, 1989

Natural gas contains no lead, produces no particulate matter, and exhausts less carbon monoxide than gasoline. Furthermore, natural gas produces virtually no hydrocarbons that the sun can turn into smog.

These clean burning qualities have already attracted the attention of companies and governments that run vehicles in densely populated urban areas. Natural gas provides the greatest benefit in heavy stop-and-go driving, where gasoline engines are more inefficient.

Courtesy of Northwestern Utilities Ltd.,
Edmonton, Alberta

FROM ALBERTA'S PERSPECTIVE



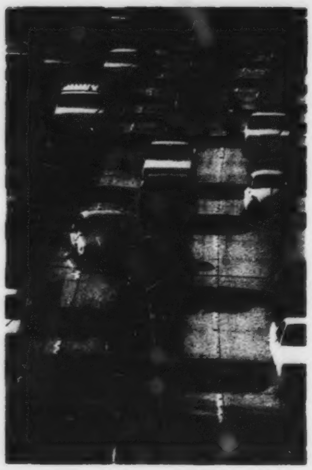
Alberta has traditionally been a resource-based economy struggling with economic diversification. We have a lot invested in development that meets the needs of the present without compromising the ability of future generations.

It would be wonderful if Alberta were responsible only for her own backyard, but she is not. There is a much larger picture — a picture so big it often overwhelms us into feeling our singular efforts couldn't possibly make a difference. So why bother, right? Wrong.

In order to bring the big picture home, the environmental impact on health is discussed from the perspective of four of Alberta's major economic sectors: oil and gas, forestry, agriculture, and petrochemical and other manufacturing industries.

Oil and Gas

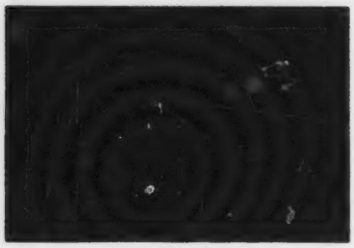
Alberta earned its reputation and secured its economic foundation on the oil and gas industry. Oil and gas deposits — in staggering amounts — are located throughout the province.



Fossil fuels drive the engine of our economy. The more fossil fuels we burn, the more prosperous we become, and — unfortunately — the more carbon we produce, contributing to global warming trends. Unfortunately, the impact of fossil fuel on the greenhouse effect may return to haunt our farmers in southern Alberta, and threaten our entire agricultural base.

We are one of the highest carbon producers per capita in the world. The Alberta Conservation Strategy projects that Alberta could save more than $700 million a year by conserving energy while reducing emissions by 15 million tonnes per year if we were to follow guidelines accepted at the "Changing Atmosphere Conference". (*Environment Views,* December 1988)

Major legislation dealing with the impact of emissions from oil and gas plants, and emissions from burning fossil fuels is contained in policy regulating air quality in cities. *The Land Surface Conservation and Reclamation Act,* under the Minister of Environment, provides the authority to order the preparation and submission of reports assessing the environmental impact of proposed developments. This affects industries such as sour gas processing plants, major pipelines and transmission lines.



The levels of certain outdoor air contaminants are monitored by both the provincial government and private industry. For example, the Strathcona Industrial Association, a group of 10 companies which owns refineries and other industries located east of Edmonton within Strathcona County, employs an independent consultant to operate six air quality monitoring stations in the industrial and nearby residential areas. The Pollution Control Division of Alberta Environment also collects data related to air quality. Air quality is not a frequently raised issue except in isolated incidents, such as when spraying is conducted for mosquito control. But in 1982, when sour gas from a natural gas well located southwest of Edmonton near Lodgepole escaped at an uncontrolled rate for 67 days, a public outcry instigated two studies on the effects of sour gas on the general population.

Alberta — the heartland of Canada's fossil fuel industry — has the opportunity to be the instigator of energy policy that promotes energy efficiency and prolongs the life of our natural resources. The province's built-in advantage on both fronts lies in the existence of the Alberta Research Council and the Energy Resources Conservation Board, both of which have been in operation for more than half a century and have established reputations for excellence. These efforts are complemented by an aggressive private sector which is world-renowned for its innovations and expertise.

Often, from adversity comes opportunity. For example, the problem of sulphur emissions from our sour gas caused Alberta to develop a major sulphur extraction process. As a result, a viable, profitable sulphur harvesting industry has emerged to make sulphur one of our leading exports.

Forestry

In southern Alberta, we are cutting the last of our original forests in an attempt to expand our agricultural land base. Our forests in northern Alberta are seen as a major economic resource for the future for another purpose — capitalizing on a renewable resource. These forests may herald the largest diversification initiative the province has seen since the oil boom.

However, as a province we have to ensure that reforestation takes place, and that the mills operate in an environmentally efficient, safe manner. While we can increase forest yields through management — from growth of two to three cubic metres per year in wild boreal forests to 12 to 15 cubic metres per year if Sweden is any example — we need to be cautious because of the health hazards of pulp processing.

"Lodgepole did more for the environmental health of this province than 20 years of writing reports and making submissions. We spent millions and millions of dollars after the fact cleaning up Love Canal, doing diagnostic studies in Pincher Creek when, if that money were spent in prevention, it would have a far greater impact on public health."
John O'Laney,
Environment Views, 1987

Calgary's GEMINI BIOCHEMICAL RESEARCH LTD. is investigating commercial applications for methane oxidizing bacteria, production of microbial pesticides, and the use of biocatalysts (such as those found naturally in methane oxidizing bacteria) to convert methane to methanol.
Alberta Department of
Technology, Research and
Telecommunications

Alberta's restocking standards are regulated through the Forestry Act timber management regulations. All harvested areas must be reforested either through planting — and millions of trees are planted annually — or natural re-growth fostered by cutting techniques. Aspen (poplar), indigenous to the northern part of the province and once considered akin to a weed, regenerates with little attention required. Spruce, however, requires assistance in its regeneration process. Overall, Alberta's cut areas that are 10-years-old and older are 96 per cent restocked. With the potential expansion of pulp and paper industries planned for northern Alberta, Alberta will need to continue replenishing her resources on a large scale. To do less, or to relax management regulations, would be shortsighted.

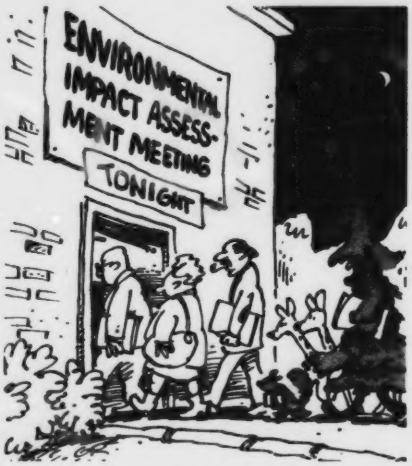
Currently there are two kinds of pulp mills — kraft mills and chemi-thermo mechanical pulp (CTMP) mills which use different bleaching processes to break down the fibre in wood chips. If toxic chemicals or by-products used are released into nearby rivers, we risk endangering water supplies and impairing the ability of the streams to supply oxygen to fish. One of the major concerns is the impact these mills will have on the Athabasca and Peace River water basins.

Organic loading of a river by pulp mills is serious: "The organic loading from one medium-sized mill is equivalent to the organic loading from the treated effluent of a city of 300,000." Alberta Environment's job is to determine if the Athabasca and Peace River basins can handle the effluent from seven large-sized mills the equivalent of the effluent from about three and one-half Edmontons or Calgarys.

Pollution has moved past smoking and alcohol abuse as the province's most pressing health concern, the president of the Alberta Medical Association says.
The Globe and Mail
Wednesday, Jan. 4, 1989

We may be buying an unknown set of environmental health issues through the cumulative effects of harvesting and processing our forests, particularly in an area already dealing with complex emissions from the oil and gas industry. While many are not convinced that there are health problems caused or exacerbated by increased exposure to pulp mill emissions, there is mounting evidence of upper respiratory tract problems (eye irritation, sinusitis, and sore throats), lower respiratory tract problems (asthma, bronchitis, and emphysema), cardiac problems and impaired pulmonary functions. Such eventualities must be taken into consideration when pulp mill projects are being assessed. The health aspects deserve as serious consideration as do the economic benefits.

The legislation for pulp mills is under the *Clean Air and Clean Water Acts.* Total reduced sulphur, sulphur dioxide, particulates, and water vapour which cause heavy winter fogs are the air emissions of concern. Both industry and Alberta government representatives state that with strict adherence to regulatory controls, environmental protection standards, and improving technology, proposed projects will not seriously jeopardize the environment.



Source: Environment Views, Vol. 11, #3, Dec 1988

Industry and departments of environment are committed to Environmental Impact Assessments (EIA), and through the Land Reclamation Act to provide early identification and resolution of significant adverse effects on the environment. However, concerns expressed about the lack of public input in Alberta's approach have resulted in a more extensive program of public hearings on proposed pulp mill projects in a greater number of localities. Citizen participation will increasingly centre on the environmental impact on health in both the short- and long-term. This public process is being considered for other forestry projects as well. The Alberta government claims that the new federal/provincial public hearing process on non-energy project assessment will serve as the role model for other provinces. Such a public process is both necessary and helpful.

Agriculture

Alberta farmers know well the issues of resource depletion — good farm land is swallowed up to accommodate urban growth. Farmers are left searching for land — often accepting less productive land that is more easily depleted. While the total land dedicated to agricultural use, approximately one-third of the land base, has remained the same, more and more is of poor quality. Again we come face-to-face with sustainable growth — something we didn't really consider a decade ago but which is at the forefront today.

"Agricultural chemicals are potentially hazardous to health — the problems lie in the fact that it is unknown what effects these chemicals will have over a period of time."
Women of Unifarm

This loss of quality land makes farmers more vulnerable to the impact of global warming. Probably the most urgent concern with respect to global warming (greenhouse effect) is the decrease in world food output — because of drought, arable lands become deserts.

While northern Alberta may actually benefit from global warming, it is of particular concern in southern Alberta where our agricultural land is in danger already because of high winds, less rainfall and intensive cropping. These factors decrease the amount of organic material in the soil and, therefore, reduce the fibre content that makes it less able to retain moisture and more susceptible to wind erosion.

If global warming goes unchecked and polar ice-caps melt, many of the low lying and heavily populated areas of the world will become flooded and the people displaced. Environmental refugees will seek out areas like Alberta that might still have agricultural land to feed them. We may be a large part of the problem and part of the solution — if we can keep our top soil in place.

Farmers, as our food producers, have a special responsibility to ensure that our food is free from toxic chemicals. Every year in Alberta, hundreds of thousands of litres of potentially toxic pesticides and herbicides are used. What has yet to be established as fact, however, is how much harm these "sleeping giants" of the chemical world can do in both the long- and short-term to the environment — and the plants, animals and people that live in it.

Agricultural producers are generally not part of land use decisions and perhaps, for all our sakes, it is time we recognized that they need to be involved. Their livelihoods depend on responsible water and land management policies and practices. Recognizing the fragility of the land base, they know they must exercise caution in their use of fertilizers, chemicals and equipment; and must depend on sophisticated technology to assist them in determining environmentally sound practices.

District Agricultural Service Boards (similar to school and hospital boards), producer organizations, district agriculturists, the federal and provincial departments of agriculture, and post-secondary institutions have been active in delivering on-farm conservation programs. Research stations and experimental farms provide other sources of information on conservation and development, chemical use, and crop and animal production to Alberta farm managers.

"It is recommended that health care put pressure on the government to address the problem of poisonous sprays used on crops in farming, and to find alternative solutions."
H. Reiswig

The Canada-Alberta Soil Conservation Initiative, a joint three-year, $34.8 million program announced in September, 1989, is part of a new $150 million national soil conservation strategy. Designed to promote conservation practices, the target issues are soil erosion, salinity, declining organic matter, and on-farm water management. Other components include purchasing marginal land for retirement from crop production; purchase or rental of special conservation equipment; provision of 1.5 million trees annually for use as field shelter belts; and a special conservation program for Indian Reserves. Professional and technical support services will be provided to accommodate transfer and extension of soil conservation technology and information, and to assist in planning, monitoring, assessment and development activities.

Such initiatives are not only welcome but necessary if we are to protect and sustain our land base and ensure continued ability to produce food.

Petrochemical and other manufacturing industries

A major factor that has put environmental health in the forefront has been the dramatic increase in the number of chemicals manufactured since the 1940s. One source estimates the number of chemical compounds manufactured in North America to be 60,000 or 70,000 — with 700 to 1,000 being added to the list each year. Many chemicals are considered "safe", some become "unsafe" in combination with others. Too often we are dealing with unknowns.

The potential for impact on our health could be enormous. Considerable attention must be given to determining the effect of exposure and consumption, and to disposing of various chemicals in a safe manner.

There is an overall lack of basic scientific knowledge of physical and chemical hazards to health. Research into the possible effects of chemicals on our health is in the early stages of development. Insufficient funding and research capability are seen as two major reasons for this late start. Greater effort and resources must be directed to such research, with major emphasis placed on determining cumulative effects of chemicals and contaminants on our health as a result of entering our air, water supplies and food chain.

Soil Conservation is Everybody's Business

Alberta
AGRICULTURE

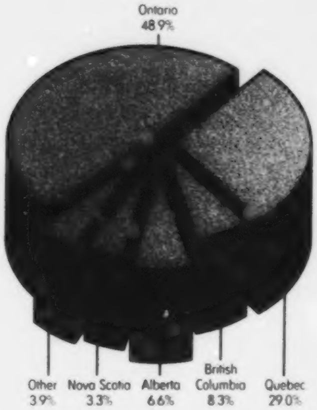
"It is recommended that there be increased emphasis on protection of the environment such as coordination and research of the quality of ground and surface water to ensure a future supply of potable water."
Big Country Health Unit

"It took centuries to prove that invisible airborne bacteria could make us sick. Now scientists are faced with an equally difficult task: proving if and how invisible air pollutants make us sick. How does acute exposure to sulphur dioxide and other chemicals affect health? We don't know. For a variety of reasons, science has not kept pace with the concern. Researchers are still developing research methods and chasing down funding to find the answers."
Alberta Heritage Foundation
for Medical Research
September/October 1989

As industrial growth and urbanization continue, monitoring, maintaining, and improving the physical environment remain a challenge. For example, although the Alberta Clean Air Act provides the legal framework and mandate for monitoring air quality and instituting pollution controls, the provincial definition of clean air is phrased in terms of excessive levels and offensive odours without explicit reference to our health. However, the federal Clean Air Act does define air pollution in terms of contaminants and their effect on human health, safety and well-being. In addition to strengthening our legislation, there is a need for stronger enforcement of regulations and higher penalties for violation.

The Toxic Trail

Hazardous waste distribution by province



Source: Environment Canada

Collection, storage, transfer and disposal of hazardous wastes — those which are flammable, reactive, corrosive or toxic — are being dealt with primarily through projects and initiatives of the Alberta Special Waste Management Corporation, in cooperation with industry and consumers. Estimated waste generated in Alberta varies between 90 000 and more than 200 000 tonnes annually, depending on various factors and activities. Approximately 68 per cent of the province's hazardous wastes are generated in the Edmonton area, and 12 per cent in Calgary.

The Alberta Special Waste Management Centre in Swan Hills is the first fully integrated special waste management facility in Canada. Current plant capacity is between 15 000 and 20 000 tonnes annually, with an anticipated 8 000 tonnes expansion. Organic wastes such as oils, solvents, paints, pesticides and PCBs are effectively destroyed by high temperature incineration. Inorganic wastes including sludges, acids, alkalis, heavy metals and cyanides are treated by physical-chemical methods such as neutralization, oxidation and precipitation. Explosives and radioactive materials which are regulated by other jurisdictions, and biological and laboratory wastes are not accepted. Disposal techniques are state-of-the-art, environmentally safe and constantly being scrutinized for improvement.

In addition to industrial and commercial waste disposal, the Alberta Special Waste Management Corporation has been developing programs to assist in the safe collection and disposal of household hazardous waste. Begun in 1988 as a pilot project involving eight communities, the first Toxic Round-up collected 34 tonnes of paint, oven cleaners, pesticides, waste oil, pharmaceuticals, solvents, photographic chemicals, antifreeze, glues, cements, wood preservatives and other household cleaning products. The 1989 collection resulted in approximately 250 tonnes from 71 participating communities. The program is expected to expand annually.

The Alberta Special Waste Services Association is currently drafting a code of ethics for its members. The plan is to have the code become a condition of membership.

Issues, problems and concerns

The Commission believes basic good health is associated with what we eat and drink, and the air we breathe. Just because our environment looks okay, does not mean we eat food free from toxins, drink water free from chemicals, or breathe air free from pollutants — cumulatively, all may affect our health status over time.

Detection of an environmental health problem has always been the first step toward developing solutions, but correlation between cause and effect is often obscure. It should be remembered that the concept of environmental health had its roots in public health — the recognition of good hygiene practices led to clean water and sewage treatment. The environmental role evolved into biophysical monitoring and analyzing, while public health became a separate entity. As a result of growing public pressure, there is a clear move away from this almost strictly biophysical approach, back to determining environmental impact on health.

We need to address how we monitor our environment, and understand how changes can affect our health. As Albertans, we can become part of the team in the global race to make our environment an asset to our health rather than an increasing threat.

There is a lack of basic environmental science: what to measure, how to measure and how to use the measurements when we have them. For instance, information on the level of air or water pollution does not, by itself, provide an understanding of the state of the environment.

Damage to the environmental resource base in Canada is occurring more rapidly than Canadian scientists can measure and understand. In order to assess and understand the impact of human activity on the environment, sustained research commitment is required. But more importantly, increased government concern is needed.

Currently, programs for collecting and reporting data are carried out by the federal, provincial and municipal governments, their various agencies, and industry. Countless reports, studies and programs are underway nationally, provincially, locally or as joint efforts — too often without benefit of coordination of existing or developing data on environmental quality and natural resources. There is no agency or institution that is clearly mandated to assemble and compile comparable environmental data or assist in its interpretation. Avoiding duplication and sharing information would result in more cost effective and efficient collection operations. Knowledge of environmental health impacts should be akin to medical break-throughs which fall into the public domain for the greater benefit of all of us.

"Environment and lifestyle interventions are seen as key determinants of health. These changes are leading to a new model of health that focuses on not only individual change but environment as well: research is needed to support the broader, more complex model."
D. Dooley

"Now we have to develop multi-causal models of disease — put a little DDT with a little air pollution and add some factory emissions and you start to have an effect on a person's health as the body burden increases."
Environment Views, 1987

"With regard to air pollution, there appear to be no accurate sources of information in Canada and it is necessary to rely on the good-will of other countries' universities, departments of the environment, health departments and independent environment groups for information."
A.F. Smith

Sustainable development — more than buzz words

The worst possible scenario would be that all of us accept that the environmental trends are irreversible…that the damage is already done…that we might as well continue our abuses.

In fact there is much that is already being done to effect positive global change, and more that can be done if the political will to get tough and follow through on plans for conservation of resources and reduction of consumption can be mustered. There is a heightened level of environmental consciousness among governments and industries who cannot ignore the overwhelming evidence substantiating environmental "negatrends".

The concept of sustainable development is most closely associated with Gro Harlem Brundtland, the prime minister of Norway and former chairman of the World Commission on Environment and Development. The Commission's report, *Our Common Future* defines sustainable development as "development that meets the needs of the present without compromising the ability of future generations to meet their own needs" — growth can only be sustainable if it is environmentally sound.

HEALTHY PUBLIC POLICY

Albertans are concerned with how the environment — the surrounding water, air, and land — affects our health. In the future, this public awareness will continue and there will be greater involvement in maintaining and using a healthy and safe environment. We must act in a less destructive manner, in order to sustain the environment and especially our health. As a result of individual action and government involvement, healthy public policy will reflect concern and ensure monitoring of the health impact; and provide the authority to enforce and control safeguards of our air, water, food, and land. We will promote research and encourage technological advances in protecting the environment in order to minimize the ill effects on the health of all Albertans.

The environmental impact on health is an area that is yet to be directly addressed by the Government of Alberta. It must become a topic not only for discussion but for research and action.

The Commission is convinced of the necessity to fully address environmental impact on health. The health of Albertans must be considered in determining economic development and job creation initiatives.

"It is recommended that the Provincial Government adopt a philosophy of 'Healthy Public Policies' and ensure that before future legislation is enacted it take into consideration the effects on the health of Albertans and that Community Health Environmental Health Services be enhanced both provincially and locally and that they work cooperatively with the Department of the Environment to improve the environmental health of Alberta."
City of Lethbridge Health Unit

As one of the Brundtland Commissioners observed, "The survival of this planet as a decent home for all who share it depends on all of us making profound changes in the way we do business."
Robert Collison, Report on Business Magazine, July 1989

"(It is recommended that the government) enforce environmental laws. If manufacturing firms continue to pollute the air and waterways, fines large enough to cover the costs of cleanup should be given for each day the infractions occur. If the fines are ignored or the infractions continue, then the company should be shut down."
Edmonton Board of Health Staff Nurses Association

"We cannot have health and a polluted environment."
L. Erickson

The current environmental impact assessment procedure under the *Land Surface Conservation and Reclamation Act* requires the analysis of impacts of proposed development initiatives on the human and physical environment, and the inclusion of proposals to avoid or lessen adverse effects. However, there is no specific requirement for health impact to be defined. This legislation must be strengthened and made more effective by specifically requiring the health dimension to be assessed. It would seem appropriate to designate Alberta Health as one of the departments to be involved in the process.

19.0 THEREFORE, WE RECOMMEND that the Government of Alberta develop an Alberta Code of Health and Environmental Ethics no later than 1992, by reviewing current policies and introducing new legislation, regulations and procedures to ensure that the health impact on Albertans is given full and equal consideration in matters of economic development and diversification, and job creation;

19.1 that the mandate of the Environment Council of Alberta be strengthened and expanded to include greater autonomy, more authority, and more responsibility in the area of the impact of the environment on health; and

19.2 that the Environment Council of Alberta work in close cooperation with the Advocate for a Healthy Alberta.

Directions for Implementation

The Government of Alberta, in drafting its proposed new environmental enhancement legislation, should include all aspects of environmental impact on health for public reaction and additional input. In the interim, existing regulations and procedures could be up-dated to ensure that environmental impact assessments include the health impact assessment as a compulsory component. Industry should be given ample warning that Alberta means business when it sets its environmental standards and spells out its health concerns for its citizens.

"It is recommended that, with regard to pollution, there should be root-level coordination among all related ministries such as Consumer and Corporate Affairs, Housing, Agriculture, Forestry, Fisheries, Education, (which is very important not only in educating the public but also in cleaning up the environment)."
E. Carlson

In the long-term, an environmental strategy should be developed using the input of citizens, policy-makers, interest groups, scientists and industry. Involvement of Health Authorities in impact studies being conducted within their jurisdictions would be significant. Such a strategy should incorporate a long-term vision, strategic direction for specific areas of impact, and convert into short-term action plans for each area that addresses issues which are urgent, important to the public, and within existing control and resource capacity at any given time. Leadership and momentum are needed to develop and implement responsive public policy.

The Environment Council of Alberta has been showing leadership, and such efforts should be encouraged and additional resources allocated if necessary to enhance the role of the Council. Rather than assuming a confrontational role with Alberta Environment, the Council should begin working more closely at establishing a more useful and on-going dialogue with the department. Integrated decision-making and collaboration among the Council, government and industry would make it more feasible to balance economic initiatives and the maintenance of a healthy environment.

In many areas, the Environment Council and the Advocate for a Healthy Alberta will share the same concerns and require similar information. Each should keep the other informed of activities on an on-going basis, establishing mechanisms to share data and support services whenever appropriate.

Research and technology to enhance the environment

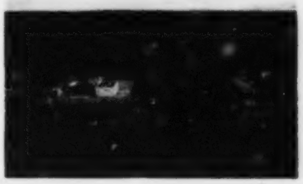
Alberta should capitalize on its forward-thinking approach to environmental matters, and expand its efforts in the development of research and technology in environmental health and protection, and renewable energy sources. The world is looking for answers, and many innovations developed for the benefit of Albertans would be marketable elsewhere.

The Alberta Environmental Centre was opened in 1979 in Vegreville, and is Canada's first interdepartmental, interdisciplinary environmental research and service agency. Close to $50 million has been invested in the Centre, which now boasts 180 researchers and staff. This world-class facility provides us with a firm foundation on which to expand our efforts here and abroad.

"It is recommended that, with regard to cleaner air and cleaner water, the government get tough on pollution and provide tax-incentives for big business to install air scrubbers and also provide tax-incentives for industry involved in waste-water management."
N. Balanko

Alberta
ENVIRONMENT COUNCIL OF ALBERTA

Suggestions are available from the Environment Council of Alberta "What I Can Do For the Environment" action list, which contains environmentally sound actions on many different subjects, from air pollution to energy, and health promotion to environmentally friendly products. If you have comments or would like to suggest or obtain additional actions on this or other subjects, please contact the Council at 800 Weber Centre, 5555 Calgary Trail Edmonton, Alberta, T6H 5P9, phone (403) 427-5792 or Zenith 06075.



Building on its success with the Swan Hills special waste treatment facility, the Alberta government has announced that it will be establishing a centre of hazardous waste management expertise. This new initiative will involve the coordination of national and international marketing of Alberta hazardous waste management, technology, research and training. As well, Alberta is working in cooperation with the ministries of Environment Canada, Ontario and Quebec and their respective provincial hydro authorities to develop and test mobile incinerators for the destruction of PCBs in central Canada.

A small number of Alberta companies, located throughout the province, are becoming involved in environmental technology — water/waste water treatment, waste incineration and recycling equipment, and electronic instruments. Few have received government subsidies, but a number count the government among their customers and some have benefited from expertise and advice provided by government agencies. The special waste treatment facility at Swan Hills is operated by an Alberta-based company, under a joint venture agreement with the Crown-owned Alberta Waste Management Corporation.

20.0 THEREFORE, WE RECOMMEND that the Government of Alberta encourage further research, development and assessment of technology, by both government agencies and the private sector and cooperatively, in environmental health and protection for application to Alberta industry;

20.1 that Alberta give priority to becoming a world leader in the development of innovative uses of recyclable materials and waste;

20.2 that a program of assistance/incentives be initiated by 1992 to encourage the development and use of renewable alternate energy sources; and

20.3 that the government support and assist the private sector involved in these activities to market their technologies throughout the world.

Directions for Implementation

"It is recommended that health and pollution should be top priorities."
G. Spielman

Much of the present public policy dealing with the environment concentrates on encouraging industries to install remedial technologies, to lessen the harm done by any environmentally harmful production. This is, in itself, a good thing. However, it should not be the whole or even the main thrust of public policy in this area. Remedial approaches to install or up-date pollution controls to production technologies are necessary at various existing facilities. Economically it will require considerable financial resources in order to meet new standards.

The prime focus of new activity must be directed at developing cleaner types of new technology — preventing pollution is better than trying to clean up afterward. The government has voiced its commitment to the environment and indicated its intention to develop and market technologies in particular areas. This base should be broadened to encompasses all aspects that could lessen the health impact of economic development and other activities.

On the premise of building on strengths, the Alberta Environmental Centre should become the forefront of activity, and receive additional funding to implement some of its innovations. It may be advisable that some of its proven technologies be turned over to the private sector for further development and marketing. The profile of the Centre should be raised within the province — internationally it is highly regarded. Its scientists should be sought out and asked for their opinions, comments and ideas by the media, the public and other government agencies.

New recycling policies being developed by the government should incorporate encouragement and incentives for the development of innovative uses of recyclable materials and for methods of rendering materials reusable.

Recognizing our economic reliance on fossil fuels, we must be cognizant, nonetheless, of the damage to the environment by carbon emissions. As well as developing alternate energy sources, Alberta should be playing a major role in the alternate uses of the energy sources we have in abundance. For example, natural gas and petrochemicals such as methanol are cleaner burning and less harmful than gasoline, yet few vehicles in Alberta have been converted. In addition to increasing the availability of fuel pumping stations, incentives could be provided for vehicle conversion.

Necessity has often been the mother of invention, and it would appear this, too, will be the case in such areas of concern as finding replacements for chlorofluorocarbons (CFCs), which Canada has agreed to ban by the year 2000. Already major work has been done on the use of helium or nitrogen as a substitute for CFC refrigerants. This is particulary welcome in light of the desire of developing countries who are just beginning to enjoy the convenience of refrigeration in their households. Such new technology must be shared early in production schedules to lessen the threat of having our intention to ban CFCs nullified. Styrene packaging and foams will have to be replaced with materials that do not threaten our ozone layer.

The Commission is confident that whatever new technologies are developed in Alberta will get the necessary support of government departments for promoting and marketing abroad.

Albertans shouldn't be concerned about future energy needs, according to RENEWABLE ENERGY: THE POWER AND THE POTENTIAL, another in a series of discussion papers prepared for the Alberta Conservation Strategy (ACS), and published by the Environment Council of Alberta. However, our renewable energy options need to be carefully studied, in the light of future energy requirements.

As the discussion paper shows, Alberta has huge potential for renewable energy sources. "The provincial government should seriously consider renewable energy as a viable alternative to today's fossil fuels," says Dr. Joan Snyder, who chairs the ACS Steering Committee.

"There's no time like the present to begin assessing Alberta's future energy needs," says Snyder. "We need to take a long, hard look at our requirements for today and the future, keeping in mind a healthy environment as our end goal."

The greening of Alberta consumers

Living in a sparsely populated and beautiful province makes it difficult for some of us to fully understand the effect we can and do have on our personal and global environments. Recycling, resource conservation, and pollution controls all seem issues for people in crowded, heavily industrialized areas. Yet our obligation and responsibility must be to our children and future generations. As individuals, we need to get involved in becoming green consumers — seeking out environmentally safe products, recycling what we can, and responsibly disposing of that which we don't need.

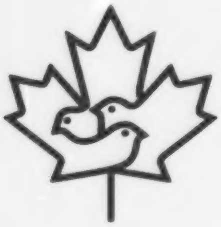
Government can be more pro-active by accepting and exceeding environmental targets. Legislation should encourage citizen and industry involvement. Although federal and provincial policies are in place for protection of the environment, the major initiatives come through *cooperation* between government and industry and from grassroots initiatives. But no one jurisdiction has the singular responsibility for the environment. This is an area where all of us must do our best to ensure environmentally healthy practices.

Understanding and awareness of what is unsafe, harmful and damaging has increased significantly...to the point where 86 per cent of Canadians have expressed a willingness to pay more for green products which are often higher priced. Taking action within our households or converting our vehicles to make them energy efficient may cost more up-front, but savings will accrue annually and be returned over time. However, paying a penalty for doing what is healthy, and sometimes less convenient, is difficult to understand.

Various business and industry sectors have recognized the value in appealing to environmentally-conscious consumers and have adjusted production methods, developed new lines of products, and designed new packaging. The federal government will put its seal of approval on goods that can be recycled, are made from recyclable materials, are free from threatening chemicals, and are less harmful to the environment. Only those goods which meet these stringent guidelines will be allowed to use the Environmental Choice Logo — the EcoLogo.

"It is recommended that Charter of Rights implications be examined concerning the responsibility of provincial legislation and enforcement in the area of environmental protection."

Special Project Committee
of the Alberta Branch
of the Canadian Bar
Association



Consumers who care about the environment will no longer have to read the small print to find environmentally friendly products. By January, you should start to see labels identifying products which are recyclable, biodegradable, free of ozone-depleting gases or made from recycled materials.

Environment Views, Vol. II, #3, Dec. 1988

"It is recommended that clear information be readily available on products containing potentially dangerous materials."
M. Peplar

21.0 **THEREFORE, WE RECOMMEND that healthy choices be made easier choices — for either or both consumers and manufacturers — because they have been made cheaper through incentives where appropriate;**

21.1 that manufacturers and merchandise outlets be encouraged and assisted in labelling those goods and products that are environmentally friendly;

21.2 that the Alberta Food Processing Centre and other similar agencies of government which assist the private sector in testing, packaging and marketing their goods and products develop and promote the use of appropriately labelled, biodegradable or recyclable containers;

21.3 that municipalities play a larger role in upgrading disposal and recycling facilities or services; and

21.4 that Alberta Environment and other departments, and the Environment Council of Alberta communicate ideas regarding individual action and responsibility through schools and to the general public on the environmental impact on health.

Directions for Implementation

Healthy choices can be made easier choices if they are cheaper or comparable in price to those goods which are not considered to be environmentally sound. It seems unfair that since the introduction of unleaded fuel, consumers have had to pay premium prices, higher prices than those set for leaded gasoline which is soon to be removed from the market because of its exceptionally high emissions of lead and carbon. Such penalties are inconsistent with the desire to clean up the environment. Rewards or incentives should be considered for either companies or consumers who are willing to do their part for the environment.

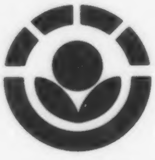
Companies which produce goods or render services that are considered to be environmentally friendly should display the new Ecologo or other universally recognized symbols indicative of this quality. Careful testing to ensure that such goods and services meet the criteria should be a prerequisite for use of the logos. If necessary, companies should receive assistance in re-designing packaging and containers. It stands to reason that publicizing the availability of such logos and the criteria for permission to use them would occur on a wide-spread basis.

THE GREEN SHOPPER

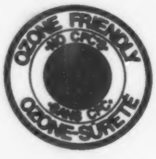
(based on July 1989 western prices; the term "green" is used to designate goods free of pesticides or other suspect chemicals.)

	Regular	Green
Large eggs:	1.45	1.95
Coffee filters:	1.59	2.19
Disposable diapers (package of 44):	10.48	9.38
1 kg Spartan apples:	1.96	2.18
1 kg celery:	.62	3.85
Spray kitchen cleaner (700 ml):	2.59	2.38
1 kg bananas:	1.28	1.65
Toilet paper (four rolls):	1.79	1.69
2.2 kg bone-shaped dog biscuits:	1.29	1.25
500 g insecticide:	6.99	6.99
1 kg sirloin roast:	[illegible]	13.17
Total:	$40.25	[illegible]

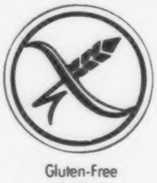
Source: West Magazine, October 1989, Vol. 1, No. 1



Irridated Food Symbol



No CFC Symbol



Gluten-Free Symbol

A You-Can-Do-It Checklist

- Recycle all paper through the blue box.
- Start putting out plastic film, cardboard and glossy paper in the blue box system this year.
- Cut down on the purchase of non-reusable and non-recyclable materials.
- Cut down on purchase of packaging materials.
- Separate mixed packaging as much as possible.
- Look for re-uses of as many items as possible locally — e.g. home projects, playschool art projects, community projects.
- Recycle bulk cardboard, paper and plastics where possible through local recyclers.
- Buy products in "environmentally friendly" packaging.
- Start composting
- Be an active lobbyist for recycling standards for the plastics industry.

Food and drug labelling is a current concern of the general population. Consumers are demanding better and more information about food and drug contents in order to be better able to make healthy choices in using these foods and other products. The Health Protection Branch of the Department of Health and Welfare Canada provides regulations concerning food contents and additives. At present, they are examining the need for stricter labelling, particularly non-medicinal ingredients in drugs, such as fillers, colouring and flavouring. According to the Allergy Information Association, at least 20,000 Canadians suffer from an allergic reaction to drugs every year, while some 5,000 per year are actually admitted to hospital mainly due to drug reaction. In Canada, three per cent of acute care admissions to hospital are allegedly due to adverse drug reaction.

Recycling programs have been extremely successful and achieved high participation rates in those areas which have been involved in such activities as Toxic Round-ups, and the blue box recycling program. These initiatives should be expanded throughout the province, and specific regulations should be put in place at the municipal level for certain disposal practices. For example, the health field, currently a major contributor to hazardous infectious wastes, should take the lead in disposing of such medical wastes from hospitals and community medical practices. Other jurisdictions might follow the Calgary Board of Health regulations governing disposal of waste from doctors' offices.

Land-fill sites are becoming an increasing problem for larger municipalities in particular. Costs are accelerating dramatically and public pressure is mounting. "NIMBY" — Not In My Back Yard — is becoming a familiar cry. Innovative recycling and waste disposal techniques, such as are being implemented in some European cities, could be considered for application in Alberta.

There appears to be no end to the number of things that can and should be done to protect and enhance the environment. Individual action is vital to this achievement, but awareness and attitude are important factors. It's easy enough to say, "If it's environmentally friendly, buy it. If it isn't, don't. If you can't re-use it, recycle it." As we expect our governments and institutions to be our role models, so must we become role models for our children. What may be a difficult adaptation for many of us who grew up as members of the disposable society could become second nature to our children…and the only choice for their children.

FIRST DRAFT, March, 2001

FINAL REPORT OF THE ADVOCATE FOR A HEALTHY ALBERTA

BUILDING ON STRENGTHS

The mandate of the Advocate for a Healthy Alberta has been fulfilled. As this is the final report to the Government of Alberta, it gives me special incentive to summarize the highlights of the past 10 years, and to provide my personal impressions of the achievements of Albertans in their pursuit of healthier lifestyles.

In late 1989, the Premier's Commission on Future Health Care for Albertans made its recommendations to the Government of Alberta after two years of deliberations. Within weeks, *The Rainbow Report: Our Vision for Health* was released to the public for their reaction and response. Over the years, most of the 21 recommendations – some in modified form – have been implemented.

My appointment as the Advocate for a Healthy Alberta became effective in April, 1991, and the functional objectives as outlined by the Commission have, for the most part, been followed. Indeed, the vision statements leading to "healthy Albertans, living in a healthy Alberta" became benchmarks of achievement as the ongoing mechanisms for review and evaluation of the health status of Albertans and the effectiveness of the health care system were developed. In keeping with the vision, the Commission's principles of People, Choice, Change, Decisions and Opportunity were frequently enunciated in conversation and correspondence with Albertans. As well, these principles continue to be used in the development and formulation of healthy public policy.

There are countless experiences that could be cited as memorable during these past 10 years. None, however, has been more rewarding and useful to me than the openness of Albertans – individuals, patients, health care providers and administrators, organizations, virtually everyone with whom I came into contact – who willingly, thus immeasurably, contributed to the process in a constructive and cooperative manner. It was their genuine desire to become involved in effecting positive change that enabled my task as the Advocate to be fulfilled.

Perhaps the most noted change over the years has been in the attitudes of Albertans — particularly toward their own approaches to health as they adopted healthier lifestyle behaviours, and to health care as they exercised personal control over choices and decisions. Pivotal to this empowerment has been the transition from centralized government decision-making about local programs and services to elected trustees responsible for regional Health Authorities. Returning control to the people within communities has had a significant impact on the relevance of priorities, programs, services and use of facilities.

Overall, health promotion and illness/injury prevention programs, for instance, have been highly successful because of the targeted approach taken in each of the Health Authorities. Having been able to look at the specific problems within their communities, the Authorities were able to design programs which addressed the needs of the people. Individuals — supported by family, friends and health care providers — have been able to relate better to such direct assistance, and improvement in their health status has resulted.

There is a substantial movement in a healthy direction which I expect will reach a plateau — that is, become the norm, the way of life — within the next 10 to 15 years. Determining the level of well-being of populations is a recent research focus, although illness and injury data were relatively prevalent previously. The office of the Advocate has recently concluded its third province-wide Health Status Report since 1992, and the results are most encouraging.

Albertans are eating better, exercising more, drinking and smoking less, and experiencing fewer illnesses and injuries. They are living longer and remain disability free for longer than ever before — we are adding life to years rather than years to life. This will pose new challenges in the coming years — how to provide meaningful and productive roles for an aging population, and how and where to care for them when they become ill and unable to fend for themselves. The scenario of children in their 60s and 70s caring for parents in their 90s and 100s will surely be commonplace.

A number of the targets set by both the Premier's Commission and the Advisory Committee on the Utilization of Medical Services in 1989 have been achieved or surpassed. For example, average birth weight has increased to 4 000 grams, and the perinatal death rate has been reduced to six per 100,000 population, still the lowest rate in Canada. The prevalence of both breast and lung cancer has been reduced, as has the incidence of cardiovascular disease. Teenage pregnancies and sexually-transmitted diseases, having declined only slightly, continue to be major concerns. Drug therapy has proven effective against AIDS which is fortunate since the incidence of the disease has continued to increase.

While people are certainly free to choose their own lifestyle, fewer and fewer are choosing to smoke because of peer pressure, cost and convenience — all public and workplaces are smoke-free. Alcohol consumption, still the highest in Canada, has decreased only marginally, although there is a decided move toward lower alcohol drinks. The social stigma and severe penalties for impaired driving [illegible]nses have resulted in a marked reduction in convictions and accidents due to drun[illegible]vers. The most dramatic reduction has been among the teenage population who have clearly heeded the message about not driving while under the influence of either alcohol or drugs. Indeed, consumption of both alcohol and drugs among all Albertans, particularly young people, has declined, and one of the major indicators is the suicide rate which has dropped to nine per 100,000.

Clearly, we still have a long way to go in achieving what is considered to be the ideal. We do know that we cannot legislate healthiness, so for the past seven years, researchers have devoted great efforts to finding techniques for motivating health-enhancing behaviours. Importantly, many of these have been incorporated in the education curriculum, which is now structured to encompass the elements necessary to attain a complete state of well-being. Since knowledge and awareness of healthy lifestyles are taught from early childhood onward, it is exciting to contemplate how sensitive and responsible future generations will be toward their own health, and how knowledgeable they will be about wise use of the health care system — when and should they need it.

What will no doubt prove itself in the coming decades is that the ability of Albertans to control their lives — to be responsible, accountable and capable of making healthy choices — is an important factor affecting their well-being. People who have a sense of self-worth, are able to determine their own destinies, and are surrounded by supportive systems are at less risk of becoming and remaining ill. I cannot stress enough that continued serious efforts by governments and communities to reduce poverty and unemployment, loneliness and isolation, and risk and disadvantage are absolutely essential.

The real success story of the Premier's Commission recommendations has been the emergence of the uniqueness of each of the Health Authorities. Despite the transition taking longer in some regions than in others, the move to local authority has been fully realized. The integration and coordination of health and social service programs and services was a massive undertaking. Those areas which already had a strong base in providing service on a regional basis were first to make the transition, and became supportive models to regions experiencing difficulties. Alberta Health worked closely and cooperatively to provide guidance and leadership to the elected trustees.

The setting of health care priorities at the local level has resulted in a redeployment in the use of facilities and institutions — all of them "specialize" in care of the sick as is most appropriate to the needs of the people in the community. In rural areas, particularly, there is a balance between acute care beds and those needed for long-term care or rehabilitation, dependent on the treatment mix required by patients. Highly complex and specialized treatment is provided at larger urban centres but patients return to their communities as soon as possible afterward to recuperate at home or in the local hospital. Technological access through satellite and computer linkages to tertiary facilities within Alberta and abroad have provided, and will continue to provide, necessary back-up to practitioners in all regions. Out-patient services have increased dramatically, as have homecare services as alternatives to institutionalization. There is a decided up-swing in the acceptance and use of substitute and alternative health care providers.

Three major reasons can be attributed to the success of the Health Authority approach to health and health care services. Firstly, while hospitals direct their primary efforts at caring for the ill and injured, some have truly become "centres for health". Working closely with community-based health agencies and organizations, hospitals that have the space, technology and staff cooperate more actively in promotion and prevention programs, and the development of extensive outreach and outpatient services.

Secondly, there has been a remarkable evolution of community care networks as the central source of information to individuals seeking to make informed choices. The networks have been the greatest influencing factor, particularly in rural Alberta, regarding selection of appropriate and alternative services and programs. Databank records in Alberta Health and Health Authorities indicate exceptionally high usage by consumers and providers of exploring options through satellite and computer facilities. Additionally, the community care networks have reinforced the joint growth of individuals and families — including the re-emergence of extended families beyond the traditional concept — with a greater community orientation that is cooperative rather than competitive.

Thirdly, the transfer of responsibility to individuals to manage health care funds — coupled with access to personal health records — appears to be off to a good start. Alberta Health is to be commended for its enthusiasm and dedication to the realization of both these goals which have been linked together on compatible systems. Indeed, pilot projects proved to be so worthwhile and successful that the program came fully on stream last year — five years earlier than had been targeted. While usage is not yet universal, there is widespread acceptance by young and middle-aged persons who have participated for three decades in the micro-chip era. Still in its early stages, patterns have yet to emerge. However, indications are that Albertans are managing their budgets well, seeking alternatives, and finding Alberta Health Care Insurance counsellors responsive to making adjustments when necessary.

New attitudes toward health have gone hand-in-hand with a greater sense of responsibility toward the environment — by individuals, governments and politicians, and the economic communities. There is a realization that economic well-being cannot be separated from individual and societal health, and the long-awaited balance has been struck.

It is with a sense of pride that I leave my post as the first and only Advocate for a Healthy Alberta. The mechanisms are in place for the ongoing collection of data necessary for us to keep track of how we are and what we need to retain a responsive, relevant health and health care system. The interdependence among the professions is much less an issue; and the relationship between practitioners and administrators is at its strongest. The partnership between providers and consumers has shown to have distinct advantages for both. As well, there has been a genuine partnership emerge between the public and private sectors that is highly beneficial to the people of Alberta.

All of us are on a journey toward a better quality of life. Our hope for the future is that new directions in well-being will be vehicles for greater human happiness, health and fulfillment.

Respectfully submitted,

The Advocate for a Healthy Alberta
March, 2001

PART SIX

CARING AND COMMITMENT

RESPONSES TO THE INTERIM REPORT ON NURSING

In February 1988, shortly after the establishment of the Commission, the Premier requested an interim report on the major concerns of nurses regarding their role in the delivery of health care in the Alberta hospital and nursing home system.

The Commission held meetings with 14 province-wide associations, and received letters and written submissions from close to 500 individuals and organizations. As well, we studied numerous national and international reports and discussion papers which we felt would be useful to our deliberations. In mid-June, the Commission submitted *Caring and Commitment — Concerns of Nurses in the Hospital and Nursing Home System*, containing 14 recommendations, to the Premier.

The Interim Report addressed the terms of reference provided to the Commission:

> To ascertain the facts and make recommendations regarding
> - the major concerns of nurses regarding their opportunity to advance academically and through increased experience in subspecialized areas of nursing care, and to have this increased expertise recognized by hospital boards;
> - the degree of physical danger to which nurses may, from time to time, be exposed through their work activity; and
> - the major concerns of nurses regarding their working conditions and rules governing employment.

We made seven recommendations on the first matter, one on the second, and six on the third.

The Premier's Commission on Future Health Care for Albertans is gratified at the prompt and comprehensive response of government to our recommendations. We also recognize that there are organizations and groups outside government who are formulating responses. We sense that changes are being initiated — that various groups are having discussions — though the impact of these changes may not yet be felt in the system.

Our early work with nurses forewarned us of the complexity of the system…that to look at nurses in isolation from other providers, patient needs, and system organization would not address the central concerns of nurses. However, we believe that the principles developed by the Commission to guide us in our overall deliberations regarding health and health care also are applicable to addressing the concerns of nurses. It is possible to take excerpts from our Interim Report, and integrate those statements with the issues of change for the entire system.

These are our five principles as they apply to nurses:

People — We believe in people being the focus of the health system.

> *"Nurses feel they have little influence on the major decisions which affect their daily activities."*

The process of nursing is centred on caring for patients. Nurses have experienced frustration in meeting the demands of a system which forces them further and further from this focus. Expectations are that they should carry out non-nursing functions, such as maintaining pharmacy and clerical records and doing housekeeping chores, and implement the care plans of other providers. Basically, most nurses like nursing. They want to spend more quality time with their patients and to be consulted on patient care.

Choice — We believe in free and voluntary individual choice, personal responsibility and duty to others.

> *"The quality of communications... is identified as a major problem. This — along with the perception by nurses that management is a highly bureaucratic, vertical and inflexible structure — contributes to the need for different management approaches."*

Nurses feel they could contribute much more to their patients' care and to the health care system if they were given the opportunity for greater involvement in the decision-making process as it relates to both. They believe their opinions of patients' conditions are undervalued and that they should be consulted more about care. Too, they have ideas on improving systems and procedures, but they are seldom asked or rewarded for innovative thinking or outstanding performance.

Nurses want more time to sit down with patients to discuss less intrusive choices or alternatives that are meaningful and nurture independence and individual responsibility.

> *"...a university degree as a minimum educational standard... reflects only one solution to the goal of increasing the education and skill levels... Many nurses would prefer to pursue the specialty route by experience, continuing education and post-basic specialty programs..."*

In order to make choices for themselves, nurses need both the opportunity and the options to make career decisions. Given the availability of courses and programs of specialty, they will be less limited in their scope. In addition to choices within their profession, they should have more choices regarding where they work within the health and health care system.

Change — We believe in the inevitability and desirability of change and in our ability to manage change to accomplish our purposes.

> *"A sense of powerlessness pervades the nursing profession.*
>
> *"Our recommendations are intended to help nurses overcome their feeling that they have no power to effect change... no voice in decision-making... no control over their daily tasks... and no authority over aspects of their work for which they are held accountable."*

Nursing is the largest profession in Canada. Nurses are important members of the health care team who fulfill the primary, around-the-clock role in caring for the ill. The nursing profession — indeed, the entire health care domain — is undergoing a transformation. The next decade will herald many changes, and nurses will have the same opportunity as others to participate in achieving their ideals, most of which centre around provision of quality care and recognition for their contribution to quality care.

Decisions — We believe in health decisions which are most effective and least intrusive.

> *"There is confusion as to who should be performing what bedside function. This confusion has resulted in each health provider group independently devising its own perception of what it should be doing. Even worse is the difficulty of working together as a cohesive unit since each group feels threatened by the other."*

Nurses, particularly on the day shift, in acute care and specialty hospitals feel they are limited in their scope and ability to do much more than follow somebody else's orders. While they may have access to the finest treatment resources, they resent bearing the brunt of cost-containment measures which have altered their responsibilities. Community-oriented nurses who work in homecare and palliative care settings are given less support and resources than their colleagues in institutionally-based intervention facilities. However, they do have more autonomy in decision-making, and more time to spend with their patients. Because they may be the primary contacts and caregivers, their chances of collarborating on treatment with other providers is greater.

Nurses may be asked to carry out procedures to which patients, families and physicians have agreed, but of which they have little or no understanding or knowledge. As the frequency of difficult decisions regarding living and dying increases, nurses will become more involved in the outcomes. Their knowledge of both the physiological and psychological status of the patient could make them useful participants in the discussions of alternatives and subsequent support to the patients.

Opportunity — We believe in making the opportunity available to all Albertans to manage their own health.

> *"Despite the existence of occupational health and safety committees in all hospitals, some nurses perceive that there are inadequate procedures in place to protect them from exposure to radiation, toxic drugs, hazardous chemicals, or infectious substances from patients; or for training staff to deal with the physical assaults by patients or intruders."*

Institutions of care must be models of healthy and safe work environments. In addition to protecting nurses and other health care providers from such obvious hazards, more attention must be paid to conditions which cause stress and conflict. Management has an obligation to promote the interdependence of the health care disciplines; to offer courses which address prevention and management of stress and conflict; and to ensure sufficient numbers of qualified staff to adequately care for patients.

At the time of publishing *The Rainbow Report: Our Vision for Health*, the government had responded to nine of our recommendations in the Interim Report. Some of the remaining recommendations call for action on the part of other stakeholder groups.

Approximately $40 million over four years was committed by the Premier through Alberta Health and Alberta Advanced Education to a variety of post-secondary programs and other initiatives, and consultative processes and advisory committees were put in place.

The majority of recommendations received positive comment and widespread support from individuals, groups and organizations. A summary of all responses by recommendation is carried in Appendix VI of Volume III.

Some of the concluding remarks in the Interim Report are worth repeating so they are retained as part of *Our Vision for Health*. They continue to bear the significance they did in June 1988.

> *"As this Commission examines the health care professions, so must the health care professions examine themselves. And, we believe that there can be a bonding among the team members. There can be a re-emergence of trust, respect and pride, not only in themselves and their chosen fields, but also in other members of the health care team.*
>
> *"The role and responsibility of the nurse has changed dramatically over the decades. The adjustment has been difficult. What has not changed is the kind of individual within society who chooses to become a nurse.*
>
> *"Nurses continue to be caring, compassionate people... dedicated to helping others... contributing to the quality of life... committed to their profession."*

The Commission views the responses to the Interim Report recommendations as the first steps in acceptance of the broader directions we have set for the achievement of healthy Albertans, living in a healthy Alberta.

PART SEVEN

GLOSSARY OF TERMS AND ABBREVIATIONS

acute care: care or treatment for illness or injury of short duration or sudden onset, requiring concentrated attention by health providers.

acute disease: a disease characterized by a single episode of fairly short duration (typically less than 30 days).

adult day care: daytime treatment and programs intended to maintain and monitor functioning for individuals unable to provide full care for themselves; used particularly by the elderly and persons with chronic mental health conditions.

advanced directive: a legal means by which patients may communicate their preferences for end-of-life decisions.

AHCIP: Alberta Health Care Insurance Plan.

AIDS: acquired immune deficiency syndrome.

AISH: Assured Income for the Severely Handicapped program.

alternate energy sources: less polluting, abundant energy sources — such as solar, wind, methane and geothermal — which could replace the use of *fossil fuels*.

alternative therapies/treatments (also called **"unconventional therapies"**): methods of prevention and treatment not generally accepted within the framework of traditional health care, e.g. acupuncture, hypnosis, biofeedback, Native spiritual practices.

ambulatory care: all types of medical care provided patients outside their homes without their admission to a health facility.

appointed guardian: a court-appointed person who takes responsibility for making personal representation and decisions on behalf of a child or dependent adult.

appointed trustee: a court-appointed person who takes responsibility for making financial decisions for a child, dependent adult or a deceased person.

attendant care: physical care provided to those who have difficulty providing themselves with basic care needs.

auxiliary hospital: a facility for the treatment of long-term or chronic illness, diseases or infirmities, or severe mental disorder.

basic insured services: those services that are approved by the Government of Alberta, after consultation with health care practitioners and consumers, and covered by the Alberta Health Care Insurance Plan.

biomedical ethics (bioethics): the study, principles and practice of good conduct with regard to biological matters.

birthing centre: a freestanding facility outside a hospital in which births take place under medical supervision.

birthing room: a homelike room or suite usually within a hospital in which women deliver their babies usually in the presence of family members and often in the absence of a medical doctor.

cardiovascular disease: any disease, such as heart attack or stroke, that pertains to or affects the heart or blood vessels.

cardiovascular fitness: physical fitness as measured by a rapid return to a normal resting blood pressure and pulse rate after moderate exercise.

case-mix funding: payment made to health care facilities based on a formula taking into account the number and kinds of services provided and the levels of illness and dependency accommodated.

CFCs (chlorofluorocarbons): synthetic chemicals used mainly as refrigerants and aerosol propellants which, once released into the atmosphere, destroy ozone molecules.

chemi-thermo mechanical pulp (CTMP) mills: those employing mechanical refiners and using chemicals such as sodium sulphite and sodium hydroxide to produce pulp.

chronic care: care provided for long-lasting or long-term illness or disability (either physical or mental).

chronic disease: a disease of long duration (more than 30 days) or frequent recurrence.

community care networks: local information/referral systems designed to assist individuals and/or families in obtaining and using community and regional services appropriately.

complementary health practitioner: person practicing *alternative therapies*, or may be used to refer to other members of traditional health care teams.

content analysis: for purposes of this report, a computerized, research information program used to store and analyze issues raised in the submissions to the Commission.

CT (or CAT): computed or computerized axial tomography — a method of imaging in which a computer is used to reconstruct the anatomic features registered by X-rays of plane cross sections of the body.

cyclosporin: a substance used as an immune suppressant to combat rejection reactions after organ transplantation.

demographics: the statistical data of a population.

designated specialty hospital: see *tertiary care hospital*.

developmental disability: impairment which occurs during the developmental years and leads to a significant loss of functioning. Major conditions include *mental retardation*, cerebral palsy and epilepsy, although many other conditions can contribute.

dignity of risk: respecting choice by patients for a particular decision regarding their own health even though it is recognized that the decision introduces a greater degree of risk and therefore may be more costly in terms of suffering and/or cost to the individual and/or society.

direct payment: monies paid by the government directly to certain persons with long-term disabilities to assist them in meeting their daily living and care needs.

disability insurance: insurance to protect against the added costs or loss of income due to a disabling or chronic condition.

EcoLogo: the Environmental Choice logo granted by Environment Canada to be carried by the "planet-friendliest" products available to help consumers make informed choices.

Empowerment: the recognition of the responsibility and power to make decisions about one's life, involving, for instance, the transfer of choice or decision from health care provider to patient.

enduring power of attorney: a legal process through which an individual can appoint another person to act on his/her behalf in estate matters, even if at a later time the grantor becomes mentally incapacitated.

environmental health: the area of study that assesses the link between the physical environment and human health.

environmental impact assessment (EIA): an examination process to determine the possible effects on the environment of a planned industrial project. Such information enables the early identification and resolution of significant adverse effects on the environment.

EPF: Established Programs Financing.

ethical living: acting responsibly and with respect for each other and the environment.

ethicist: a person who specializes in the study, understanding, and communication of ethical principles.

euthanasia: the act or practice of killing hopelessly or painfully sick individuals (active euthanasia) or of allowing them to die in comfort without all possible treatment (passive euthanasia) for reasons of mercy.

extended care: care required by a person with a relatively stabilized chronic disease or functional disability who requires the availability of personal care on a 24-hour basis with medical or professional nursing supervision for a period of months or years.

FCSS: Family and Community Support Services.

fertility rate: the number of live births to women of child-bearing age in a population for a given year (per 1000).

fossil fuels: coal, oil and natural gas.

functional illiteracy: the inability of an individual to engage in those activities in which reading, writing and calculation are required for his own and his community's development.

glasnost: openness; voicing one's opinion openly, freely, most commonly associated with new freedoms in the Soviet Union.

global warming: the increase in the average surface air temperature of the earth because of the *greenhouse effect*.

green consumers: environmentally aware and concerned people who are informed about the environmental costs of the products they buy and the services they use. They aim to reduce consumption, to recycle and reuse materials and refuse to buy polluting products.

greenhouse effect: the entrapment of heat by the blanket of accumulated gases in the earth's atmosphere.

greenhouse gases: those gases which contribute most directly to *global warming*: primarily carbon dioxide (produced by the burning of *fossil fuels*), nitrogen oxides, freon and methane.

Gross Domestic Product (GDP): the annual value of all goods and services produced by an economy, provincially (Gross Provincial Product, GPP) or nationally (Gross National Product, GNP).

HIV: human immunodeficiency virus.

Holistic: a description of methods of disease prevention and treatment that involve not only the physical, but the mental, psychological, and emotional needs and lifestyle/home situation of a patient.

homecare: health services provided in the homes of the elderly, disabled, sick or convalescent, and which can include nursing care, social services, homemaker services or *rehabilitation* services.

hospice: a program providing *palliative*, supportive and *respite care* for terminally ill patients and their families; a health-care facility for the terminally ill that emphasizes pain control and emotional support for the patient and family, typically refraining from extraordinary measures to prolong life.

hydrocarbon fuels: carbon-based energy sources including *fossil fuels*, wood, peat and dung.

illiteracy: lack of ability to read and write (see also *functional illiteracy*).

Incentives: monetary or non-cash benefits used to reward a change in activities that minimizes cost to the health system and/or maximizes service to the public.

in-patient care: care given to an individual who has been admitted at least overnight to a hospital or other health facility.

infant death: the death of a child between birth and one year of age.

infant mortality rate: the number of *infant deaths* per 1000 live births in a year.

key-word system: the Commission's method of retrieving specific information related to issues contained in the *content analysis* system.

kraft mills: those which make wood pulp by digesting wood chips in an alkaline solution of caustic soda and sodium sulfate (the "sulfate process"). Kraft is the type of heavy paper (usually brown) used chiefly for bags and wrapping paper.

labour force participation rate: the percentage of the total labour force as a proportion of the adult population 15 years of age and older.

labour force participation ratio: the comparison of the number of people in the labour force with those who are not in the labour force in an adult population that is 15 years of age and older.

least intrusive: involves discussions with patients which ensure understanding of the process involved in diagnosis and/or treatment of disease such that the most appropriate and least complicated and worrisome process is used.

long-term care: support and maintenance services provided on a prolonged basis, either continuously or intermittently, to individuals whose functional capacities are chronically impaired or at risk of impairment.

medically required service: in Alberta, any services provided under the Alberta Health Care Insurance Plan by a licensed medical practitioner.

mental health: the capacity to interact with others in ways that promote well-being, the optimal development and use of mental abilities, and the achievement of individual and collective goals.

mental illness: a disorder of thought, mood, perception, orientation or memory which grossly impairs judgement, behaviour, capacity to recognize reality, or ability to meet the ordinary demands of life but does not include *mental retardation* nor disorders which are restricted to relationships between the individual and society.

Montreal Protocol: an agreement signed in 1987 by Canada, the U.S., the European Economic Community and 21 other countries to reduce world *CFC* consumption 20% by 1993 and another 30% by 1998.

morbidity rate: the number of cases of disease per 1000 population in a given time period.

mortality rate: the number of deaths per 1000 population in a given time period.

MRI: magnetic resonance imaging; a technique for reviewing internal organs by using the response or resonance of nuclei of atoms of one of the bodily elements to externally applied magnetic fields.

natural increase in population: births minus deaths.

neo-natal: refers to a baby's first four weeks of life.

net migration: the difference between the number of people moving into and out of a given area for a given time period.

nurse midwife: a registered nurse with special training in the management and care of mothers and babies throughout the reproductive cycle, pregnancy, labour, delivery and birth.

nursing home: any of a wide range of in-patient health care facilities, other than hospitals, which provide various levels of attendant and nursing care to people unable to care for themselves.

organic loading: dispersing wastes into water systems in quantities that promote rapid growth of aquatic vegetation thereby depleting oxygen and animal life. Also applicable here is the broader term "nutrient loading" which is the excessive dumping of substances containing nitrogen, hydrogen, phosphorus and/or carbon leading to increased plant growth until other nutrients or light availability become limiting.

orthotic devices: medical appliances that support or brace weak or ineffective joints or muscles.

outreach services: assessments and treatment services provided within a person's natural environments — home, work, leisure, etc.

ozone layer: stratospheric layer between 15 and 35 kilometres above the earth's surface that protects the earth from damaging ultraviolet radiation.

pain clinic: place where individuals receive treatment alternatives designed to reduce or manage chronic pain, usually under the care of a multidisciplinary team.

palliative care: that which relieves or lessens without curing; a program of active, compassionate care, primarily directed at easing the dying process for the patient and the family.

particulates: undissolved particles of matter in liquid or solid form suspended in air or water.

pastoral care: holistic support and counselling of a spiritual nature.

PCBs (polychlorinated biphenyls): man-made toxicants (poisons) found primarily in electrical transformers.

perinatal death: death of a foetus/infant during the late prenatal period (20th to 29th week of gestation), the birth process or the first seven days of life.

personal care services: assistance with personal and domestic routines of daily living, usually provided by a trained attendant.

personal portable debit card: a *smart card* that allows consumers to transfer health care funds accredited them by the government to government-approved health care providers of their choice; a means to implement *personal portable funding*.

personal portable funding: a health care payment system in which individuals pay for the government-approved health care of their choice with credit allotted to them by the provincial department of health.

physician services: any medically required services rendered by medical practitioners.

poverty line: the point at which 58.5% of one's income is required for the essentials of food, clothing and shelter.

power of attorney: a legal process through which an individual can appoint another person to act on his/her behalf in estate matters as long as the grantor is mentally competent.

PRIDE: Parents' Resource Institute for Drug Education.

primary care hospital: one which provides routine obstetrics, medicine, some general surgery and emergency care but does not require specialized equipment or the skills of specialists.

prosthetic devices: medical appliances that act as replacements for missing body parts.

psychological health: see *mental health.*

public general hospital: see *primary general care hospital* and *secondary care hospital.*

Public Guardian (Office of): the government branch which administers the guardianship provisions of the *Dependent Adults Act* by studying all guardianship applications and making appropriate recommendations when they are presented to the Court.

Public Trustee (Office of): the government branch which administers the Public Trustee's Act regarding financial matters of dependent adults, the estates of minors, the estates of deceased persons with no legal representation in the Province of Alberta, and companies in liquidation.

quick response teams: health care practitioners who screen the admission to hospital of older patients by determining if they can be cared for at home and then making arrangements for appropriate home care.

referral hospital: see *secondary care hospital* and *tertiary care hospital.*

regional hospital: see *primary care hospital.*

regionalization: the planning and management of health care services within geographic subdivisions so that programs and services can reflect local needs.

rehabilitation: the action, methods or process of restoring disabled people to maximum functioning, independence and adjustment, and of preventing relapse or recurrence of illness.

respite care: patient care provided intermittently in the home or institution in order to provide temporary relief to the people who are providing continuous care to the patient in the home.

robotics: the technology connected with using computer-controlled machines to perform manipulative tasks.

SAL: Social Allowance program.

secondary care hospital: a facility equipped to handle the majority of medical problems and accept referrals for specialty care from *primary care hospitals.*

self-help groups: groups of persons who share a common concern and who provide support and mutual assistance to each other.

smart, supersmart and optical cards: portable, credit-card-sized electronic cards or discs on which personal and confidential information can be stored for utilization in the administration of health care.

specialist (consultant): a health care practitioner whose practice is limited to the study and treatment of one class of diseases or whose professional interest is confined to specific organs or systems within the body.

specialized active care hospital: see *secondary care hospital* and *tertiary care hospital.*

STDs: sexually transmitted diseases including chlamydia, syphilis, gonorrhea, *HIV* and *AIDS.*

supplementary insurance: insured coverage for health care services which are not wholly insured by the provincial health insurance plan and which constitute the basic health services provided under uniform terms and conditions to all residents of Alberta in conformance with the Canada Health Act.

surgi-centre: a facility that serves outpatients requiring surgical treatment exceeding the capacity of a physician's office but not requiring hospitalization as an inpatient.

tertiary care hospital: highly specialized active care facility accepting patients by referral; usually associated with research, teaching and training.

therapeutic abortion: interruption of pregnancy by artificial means for medical considerations.

toxins: used here to mean "toxicants," chemical poisons.

unemployed: those without work but available for and looking for work.

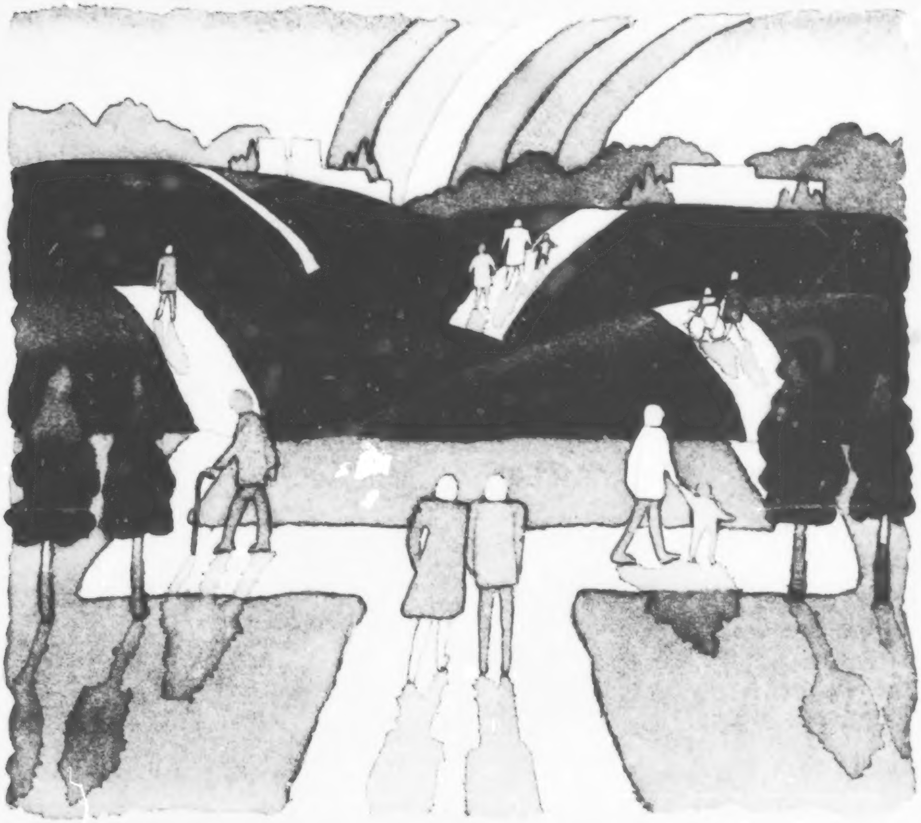
unemployment rate: a representation of the *unemployed* as a percentage of the labour force (i.e., those people who have or are looking for jobs).

volunteer society: the segment of the population who offer their professional or personal services on their own initiative without pay.

Volume

3

THE RAINBOW REPORT: OUR VISION FOR HEALTH



VOLUME III

PREMIER'S
COMMISSION
ON FUTURE
HEALTH CARE
FOR ALBERTANS

FINAL REPORT
DECEMBER 1989

Your response to **The Rainbow Report: Our Vision for Health** is welcome.

Comment directly to your Member
of the Legislative Assembly

or before March 31, 1990 to
Premier's Commission on
Future Health Care for Albertans
17th Floor, 10025 Jasper Avenue
Edmonton, Alberta, Canada T5J 3Z3

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Part Four **The Journey**

Acknowledgements

VOLUME TWO — DIRECTIONS FOR CHANGE

Part Five **Healthy Public Policy**

Epilogue **Building on Strengths**

Part Six **Caring and Commitment**

Part Seven **Glossary of Terms and Abbreviations**

APPENDIX 1

TERMS OF REFERENCE

1. In this Order "Commission" means the Premier's Commission on Future Health Care for Albertans.

2. There is hereby established a Commission called the "Premier's Commission on Future Health Care for Albertans."

3. (1) The Commission shall consist of the following members:

   (a) Louis D. Hyndman, Q.C., Edmonton, Alberta;
   (b) Joy D. Calkin, Dean of Nursing, University of Calgary;
   (c) Ruth L. Collins-Nakai, M.D., Edmonton, Alberta;
   (d) C. Eugene Murrant, Businessman, Manning, Alberta;
   (e) Father Patrick B. O'Byrne, Calgary, Alberta;
   (f) Carol R. Snedden, B.Sc., Home Economics, Medicine Hat, Alberta;
   (g) William L.C. Sturgeon, Businessman, Edmonton, Alberta.

   (2) The member referred to in subsection (1)(a) is hereby designated as Chairman of the Commission.

4. The Commission is to conduct an inquiry on future health requirements for Albertans with respect to these general terms of reference:

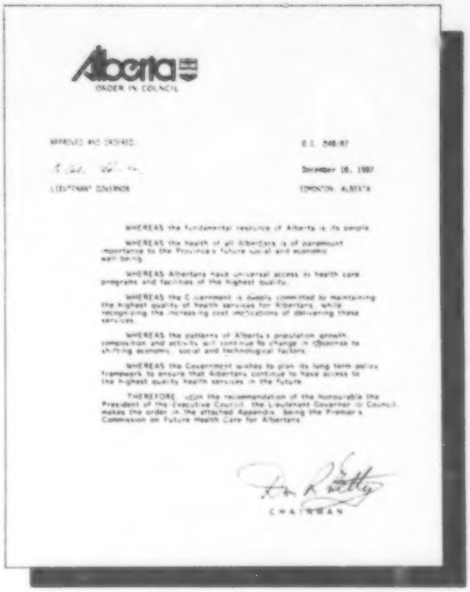
   (a) to examine changes in future health requirements as they relate to population trends, advances in active treatment and preventative health measures, health training and technology, types and patterns of illness, public needs and expectations, organization funding structures, and such other factors that may be relevant;

   (b) to examine the roles, responsibilities and expectations of individual Albertans, volunteers, community agencies, the medical and related health care professions, private sector interests, and governments in planning, delivering and funding future health services and programs;

   (c) to examine incentives and mechanisms to maintain the quality and accessibility of health services; to encourage the most innovative, effective and economical use of health resources and to focus on the promotion of health and the prevention of disease; and

   (d) to examine, comment on, and make recommendations on such other matters that the Commission may deem to be relevant.

5. The Commission shall report to the Premier as quickly as possible utilizing such interim reports as may be necessary, with a final report and recommendations on or before December 31, 1989.



Alberta
ORDER IN COUNCIL

APPROVED AND ORDERED: O.C. [illegible]

December 18, 1987

LIEUTENANT GOVERNOR EDMONTON, ALBERTA

WHEREAS the fundamental resource of Alberta is its people.

WHEREAS the health of all Albertans is of paramount importance to the Province's future social and economic well being.

WHEREAS Albertans have universal access to health care programs and facilities of the highest quality.

WHEREAS the Government is deeply committed to maintaining the highest quality of health services for Albertans, while recognizing the increasing cost implications of delivering these services.

WHEREAS the patterns of Alberta's population growth, composition and activity will continue to change in response to shifting economic, social and technological factors.

WHEREAS the Government wishes to plan its long term policy framework to ensure that Albertans continue to have access to the highest quality health services in the future.

THEREFORE, upon the recommendation of the Honourable the President of the Executive Council, the Lieutenant Governor in Council makes the order in the attached Appendix, being the Premier's Commission on Future Health Care for Albertans.

CHAIRMAN

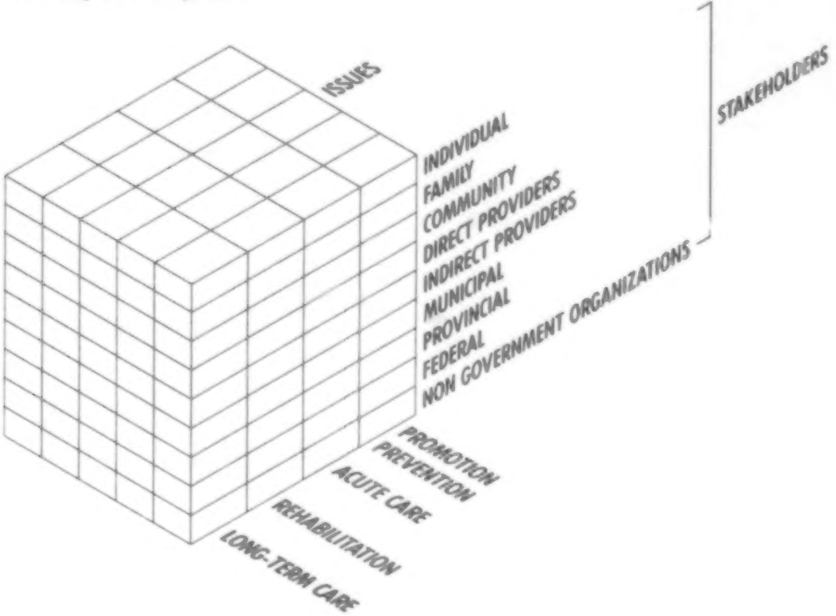
APPENDIX I

APPLYING THE TERMS OF REFERENCE

Introduction

The Commission started its task by researching issues according to each of the terms of reference. A cubed matrix was devised to try and show the relationships among the terms of reference. This way of thinking allowed the Commissioners to initially consider the issues in terms of collective experience and wisdom. Terms of Reference A (problem issues) and C (possible solutions for issues) were the "issues" dimension of the cube. Terms of Reference B comprised the "stakeholders" dimension. The third dimension represented the four major sections of the health system (health promotion and disease prevention, acute care, rehabilitation and long-term care).

Health System Components


ISSUES
STAKEHOLDERS
INDIVIDUAL
FAMILY
COMMUNITY
DIRECT PROVIDERS
INDIRECT PROVIDERS
MUNICIPAL
PROVINCIAL
FEDERAL
NON GOVERNMENT ORGANIZATIONS
PROMOTION
PREVENTION
ACUTE CARE
REHABILITATION
LONG-TERM CARE

In the process of the presentations and hearings, many other issues arose. Each issue was divided into its "problem" and "solution" component. From the solutions, the Commissioners distilled the characteristics for an "ideal" health system for the future. Next, we identified the principles which seemed to underlie and guide this ideal system. These principles were tested by meeting with many individuals and groups in both formal and informal settings. One formal method was a series of two surveys which were conducted on a total of 513 Health Administration students primarily from western Canada in 1988 and 1989.

The Commission used the feedback from these sessions to refine our principles for the health system. Based on these principles, we developed a vision for the future health of Albertans. This vision was a holistic picture of what the health system should look like and do in the future. Once we established our vision, we worked back in time to today, noting what events would have to occur in what order and by what time if the vision was to be realized. These events became the basis for the recommendations.

APPENDIX I

Terms of Reference and Six Directions for Change

Following are the Six Directions for Change presented in Volume I pages 27 and 28, and Volume II pages 6 and 7, as they relate to each of the three specific Terms of Reference. These directions are illustrative of how all of the recommendations can relate to the Terms of Reference.

Terms of Reference

4(a) To examine changes in the future health requirements as they relate to population trends, advances in active treatment and preventative health measures, health training and technology, types and patterns of illness, public needs and expectations, organization funding structures, as other such factors that may be relevant.

Directions for Change

— appoint an Advocate for a Healthy Alberta
— establish nine Health Authorities

4(b) To examine the roles, responsibilities and expectations of individual Albertans, volunteers, community agencies, the medical and related health care professions, private sector interests, and governments in planning, delivering and funding future health services and programs.

Directions for Change

— establish a publicly-accessible Ethics Centre
— appoint an Advocate for a Healthy Alberta
— establish nine Health Authorities

4(c) To examine incentives and mechanisms to maintain the quality and accessibility of health services; to encourage the most innovative effective and economical use of health resources and to focus on the promotion of health and the prevention of disease.

Directions for Change

— provide one per cent more of Alberta Health's operating budget specifically for prevention and promotion programs
— establish an Alberta Code of Health and Environmental Ethics
— explore the option of providing a personalized funding system

APPENDIX I

OUR MISSION STATEMENT, PRINCIPLES AND ESSENTIALS

The Mission Statement, Principles and Essentials resulted from our participation at public meetings all over the province, from information gained through briefs presented at public hearings, from internal research and from many hours of discussion among Commissioners. The Commissioners feel that these should constitute the philosophy and major values of our future health system. All future changes should be measured against them.

OUR MISSION

is to develop recommendations that will make Alberta in 2000 A.D. and beyond, a province where:

Healthy	I.	Each citizen has the opportunity to achieve quality of life through "good health," not only physically, but also in the mental, spiritual, social, ecological and economic spheres.
Health	II.	Albertans, individually and within their families and communities, play the major role in the maintenance and enhancement of their health.
Health Care	III.	Albertans, with the appropriate assistance of others, have the opportunity to attain or restore themselves to optimal health, or to die with dignity.

PRINCIPLES

People • We believe in people being the focus of the health system.

Choice • We believe in free and voluntary individual choice, personal responsibility and duty to others.

Change • We believe in the inevitability and desirability of change and our ability to manage change to accomplish our purposes.

Decisions • We believe in health decisions which are most effective and least intrusive.

Opportunity • We believe in making the opportunity available to all Albertans to maximize their own health.

APPENDIX I

ESSENTIALS

The elements shown (which could also be called "goals" or "objectives" or "building blocks") are not in any order of priority. In our view, they are essential parts of our future health system. These are important directions in which we should be going in the health system.

Control

Individuals will take the responsibility to make or delegate all the health care and health decisions they can because people have significant differences and ideas about what makes them healthy, and a sense of control is in itself health. We will accomplish this by assuring that we all have adequate knowledge about health and health care, including most appropriate/least intrusive options, assuring that standards, policies, legislators and other "organizers" support us in self-determination regarding health and health care, and assuring access to health and health care (recognizing always that societal restrictions may limit self-determination).

Health Knowledge

We intend to create and make knowledge available to Albertans in order to assure their control of the nature and amount of health and health care by identifying areas of knowledge needed, disseminating it, and conducting ongoing review and evaluation.

People are the Core

We intend to ensure that persons, well and unwell, are central to the health system so that individual needs are best met by recognizing that people have the power ($ and knowledge) to control the system.

Environment

We intend to recognize, analyze the environment and act on it in a non-destructive and balanced manner in order to produce a sustainable environment for health by encouraging individual action and healthy public policy.

Assuring Access

We intend to provide linkages between people and the essentials of the health system in order to assure access to the health system by creating ways that will allow people to use the system easily.

Human Relationships

We intend to recognize, analyze, and positively influence the role of human relationships in health care (in order to contribute to the level of health by encouraging supportive family and community action and healthy public policy).

APPENDIX I

Change

We intend to develop a system that is responsive to change so that we can quickly re-align resources as to areas of need by designing a plan to deal with change.

Basic Needs

Whereas we recognize that factors such as (but not limited to) food, clothing, shelter and education have significant impact on health, we intend to ensure that these basic needs are met by increasing knowledge of these factors and health, by evaluating the extent of poverty in Alberta, and taking the actions that are needed.

Resources

Whereas effective management of human, financial and other resources has an impact on the quality of our health system, we intend to use our human and other resources efficiently by respecting and enhancing individual skills and abilities and encouraging fair distribution of resources and innovative ways of resource development and by relegation to the lowest level of authority that can perform the function.

Our Future

We intend to protect and invest in children's health so that the health system becomes sustainable.

Principles/Beliefs

We intend to assure that there are publicly stated principles and beliefs about health that ensure there is a foundation upon which the health system in Alberta is built by creating a process for writing and regularly reviewing these beliefs.

APPENDIX II
COMMISSION MEMBERS

Lou Hyndman
Chairman

Lou Hyndman, Q.C., a native Edmontonian, was born on July 1, 1935. He received his B.A. in 1956 and his L.L.B. in 1959, from the University of Alberta.

Mr. Hyndman practiced law in Edmonton from 1959 to 1971. Elected to the Alberta Legislature in 1967, he served for five successive terms until 1986. He was Minister of Education 1971-1975, Minister of Federal and Intergovernmental Affairs 1975-1979, Government House Leader 1971-1979, and Provincial Treasurer 1979-1986.

In addition to serving as Chief Commissioner of the Premier's Commission on Future Health Care for Albertans, he is a senior partner of the Edmonton law firm of Field and Field. As well, he is a member of the board of directors of a number of Alberta and Canadian companies.

He is also a director of the Goodwill Rehabilitation Association, the Alberta Association for Children and Adults with Learning Disabilities, and The Boy Scouts of Canada, and headed up the Project Leadership fund raising project for the University of Alberta.

Mr. Hyndman and his wife Mary have two sons, Bruce and Peter, and a daughter Jennifer.

Alex McPherson
Deputy Commissioner and
Executive Director

Dr. Alex McPherson was born in Calgary, Alberta on March 1, 1939 and lived in several small towns in Alberta. He graduated from Vermilion High School in 1956 and received his M.D. from the University of Alberta in 1962.

Alex received his Ph.D., and specialty medical training in Australia from 1964-69. He joined the staff of the Department of Medicine at the University of Alberta as an Associate Professor in 1969 and has been a full Professor since 1977.

Alex was Director of Medicine at the Cross Cancer Institute from 1972-1985. He also served as Deputy Minister of the Department of Hospitals and Medical Care, for the Alberta government from September 1985 to January 1988.

His professional activities include membership in a variety of professional societies. He is also a Fellow of the Canadian, Australasian, and American Colleges of Physicians. Alex played a significant part in patient research on Interferon in Alberta and is also the author of numerous articles. He is Past-President of both the Alberta and Canadian Medical Associations.

An experienced administrator and an authority on policies, procedures, funding and management in the health care system, Dr. McPherson consults nationally and internationally.

Dr. McPherson and his wife Anne have four children and reside in Edmonton.

Joy Calkin
Commissioner

Joy Calkin was born on the 7th of April, 1938. She received a B.Sc. in Nursing at the University of Toronto, an M.Sc.N. in Pediatrics at the University of Wisconsin-Madison and a Ph.D. in Health Services Administration at the University of Wisconsin.

After working as a staff nurse in Canada, and the United Kingdom, Joy Calkin became a Professor of Nursing and Medicine in the U.S.A. For ten years she worked as a management consultant in health care systems. From 1985 until 1989, she was Dean of Nursing at the University of Calgary and is currently Vice President (Academic) & Provost Elect. In addition to her role as Commissioner, she is involved extensively in multi-disciplinary education, consultation and research in health care focusing recently on specialization and advanced nursing practice. She has trained and studied extensively in children's health and specialized nursing of children with chronic illnesses such as diabetes.

Dr. Calkin is a member of many organizations from Ireland to Calgary, including nursing organizations such as the Alberta Association of Registered Nurses (AARN). Her professional activities include work with the American Society for Critical Care Medicine on Cost Containment and the American Association of Critical Care Nurses in national study centre for cost-effectiveness.

Perceptive, humorous and well-informed, Joy is an excellent communicator. She enjoys sharing her vast knowledge of the health care system and practical experience gained as a nurse, educator, administrator and consultant.

Ruth Collins-Nakai
Commissioner

Dr. Ruth Collins-Nakai was born in Pincher Creek, Alberta on March 27, 1949. She attended school there then proceeded to the University of Alberta for undergraduate studies.

She received her medical degree from the University of Alberta in 1972, and pursued specialty and sub-specialty post-graduate training at McGill University, the University of Alberta, and at Harvard University in Boston. Ruth joined the staff of the Department of Pediatrics in Pediatric Cardiology at the University of Alberta in 1977 and became a Professor of Pediatrics in 1988. She was instrumental in forming the Heritage Pediatric Cardiology program for northern and central Alberta and continues to be actively involved in teaching and developing innovative therapies in this area.

Dr. Collins-Nakai is a Past-President of the Alberta Medical Association, being the first woman to hold the office of President. She holds memberships and offices in numerous organizations including the Canadian Cardiovascular Society, Canadian Pediatric Society, Canadian Medical Association, the American Academy of Pediatrics, and is a Governor for the American College of Cardiology.

A zealous energetic woman, Dr. Collins-Nakai is deeply committed to her profession and the pursuit of excellence in all aspects of her work including patient care, counselling, teaching, and consulting.

Dr. Collins-Nakai is married to Dr. S.S. (Nick) Nakai, an Edmonton cardiovascular-thoracic surgeon, and they have two children, Natasha and Sunil.

Gene Murrant
Commissioner

Mr. C.E. (Gene) Murrant was born in Camrose, Alberta, on October 16, 1932.

Since finishing high school, he has been owner and operator of a private business, B & G Electric and Plumbing Ltd., in Manning, Alberta. Gene's special training includes certification as a Master Electrician, a Master Plumber, and a Gas Fitter.

In addition to managing his business, Mr. Murrant is Past-President of the Electrical Contractors Association of Alberta. He is Vice-President of the Manning Board of Trade and a former trustee and Vice-Chairman of the Manning Hospital Board. He has also served on the Canadian Hospital Association Board of Directors, and the Canadian Hospital Association Finance Committee, and is Past-President of the Alberta Hospital Association.

In addition to his hospital related background, Mr. Murrant brings a small-town, rural flavour to the Premier's Commission. He is an outdoorsman, whose hobbies include golf, windsurfing, fishing, and down-hill skiing. He is an expert pilot and finds the adventurous hobby of flying most practical for his demanding, day-to-day work schedule.

Mr. Murrant is married with two children and six grandchildren.

Father Patrick
Bernard O'Byrne
Commissioner

Father Patrick Bernard O'Byrne was born on August 22, 1914 in Calgary, Alberta.

After graduating from high school in Calgary, he attended the University of Toronto's Philosophy Department, majoring in Social Affairs (1932-1936). After that, he attended St. Augustines Seminary for four years in Toronto. Later, Father Pat studied Social Work at St. Louis University (1945-1946).

His dedicated community, family service and parish work have spanned almost fifty years with the roots in Calgary, Alberta. He was Assistant Priest St. Mary's, Calgary (1940); Catholic Youth Association of Canada (1945), Catholic Family Service of Calgary (1957-1967); Council of Social Affairs (1967-1977); and Pastor-Claresholm, Alberta (1947-1957).

Father Pat's other special distinctions include being the first Alberta Chairman of the Canadian Council of Children and Youth, Director of Inter Faith Programs, conciliator of the Alberta Board of Industrial Relations, and L.L.D, University of Calgary.

Father Pat's warm, caring nature and his insight, beliefs and experience with people of all walks of life brings a special perspective to the Commission's work. In addition, he's still active in social work, the Diocese, and in the community.

Father O'Byrne has two brothers, Dan and Paul, and two sisters, Mrs. Mary McLean and Mrs. Margaret Haun.

Carol Snedden
Commissioner

A resident of Medicine Hat since 1956, Mrs. Carol Snedden was born in Southern Alberta, in Lethbridge, on February 19, 1935.

After graduating with a B.Sc. in Home Economics from University of Alberta in 1956, she worked at the Defense Research Station in Suffield, Alberta as a Laboratory Assistant in Physiology and Biochemistry from 1956-1959.

Carol has been extensively involved with numerous associations. She has been a member of the Provincial Hospitals and Medical Care Policy Advisory Committee from 1978-1986; Representative of the Medicine Hat Regional Hospital Planning Committee from 1975-1987; a founding member of the South Eastern Alberta Community Resources Centre Board (1973-1977). She has also been President of the United Church Women, and one of the first two women to serve on a new combined Board of Elders. Carol's other offices held include Vice-President of the Waterton Lakes National Park Leaseholders' Association; President of the Medicine Hat Ladies Curling Club; President and Secretary of the Medicine Hat Kinette Club; and Treasurer of the Fibre Arts Society.

Very politically astute and a hard-working dedicated community supporter, Carol has been generous with her time and talents in numerous volunteer organizations and projects.

She is married to Dr. J.M.H. Snedden, with children Dr. Shann Mayer, Megan Fischer, Marty Snedden, and Lisa Mackey. She has one granddaughter.

William Sturgeon
Commissioner

William (Bill) L.C. Sturgeon was born on January 15, 1932 in Meaford, Ontario. His early education was in small-town Ontario, after which time he attended the University of Western Ontario and graduated in Honours Business Administration. He moved to Alberta in 1965 and has since become a confirmed Westerner.

From 1965 to 1989 he owned Consumer Welders Supplies, Inc. Bill has served as President and is currently advisor to their management board. He has extensive training in business management, human resources, and other professional areas. Bill was the first Canadian President of the International Welding Supply Association. Other involvements include being a Trustee of the University Hospitals Foundation and member of the 75th Anniversary Committee of the Faculty of Medicine, University of Alberta.

When he's not sharing his expert businessman's point of view on the Commission's work on future health care, Bill keeps healthy with a superb game of golf.

Mr. Sturgeon and his wife Jane have four children and three grandchildren.

APPENDIX III
COMMISSION STAFF, CONSULTANTS, CONFERENCE FACILITATORS, AND ACKNOWLEDGEMENTS

STAFF

Deputy Commissioner and Executive Director

Alex McPherson, M.D., Ph.D.

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Gisele Chartrand, File Clerk
JoAnne Elniski, File Clerk
Mark Fenton, B.A., Record Supervisor
Chris Genesis, Administrative Assistant
Shirley Hlushak, Secretary
Brenda Howorko, Secretary
Jane Jack, Executive Secretary
Amanda Kenyon, File Clerk
Nancy King, Secretary
Gary Lachance, Communications Assistant
Emmie Leung, Secretary
Carol Morgan, B.A., M.L.S., Librarian
Elisabeth Reib, Secretary
Marion Saffran, B.Ed., M.L.S., Librarian
Kristine Stannard, Clerk
Ruby Stewart, Secretary
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Bloomer, Newcomb
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Clarke, Suzanne (Mrs.)
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Szymczak, Viktor
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Thompson, A.H. (Dr.)
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Bernie McKay and Associates
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Candella Group
Chan Durrant Communications Ltd.
CPM Planning Services Ltd.
Grant MacEwan Conference Centre
H.C.A. Healthcare of Canada Inc.
Heath Risk Management, Inc.
Hewlett Packard
Home at Last Ltd.
Humanite Services Planning Ltd.
Kerr & Friends
Maureen Payne and Associates
McQ Enterprises Ltd.
N.J.M. Services
Process Consulting and Research Ltd.
R.H. McVicar and Associates
RPM Planning Associates Limited
Seacrest Consulting Company
Square One Management Ltd.
Status Plus Public Relations Inc.
Peat, Marwick, Stevenson & Kellogg
T.D. Weiden & Associates Ltd.
The Percy Group
The Performance Management Group
University of Alberta, Western Centre for Economic Research
Van Mechelen Sound Services

CONFERENCE FACILITATORS

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Vargo, Fran (Dr.)

APPENDIX III
ACKNOWLEDGEMENTS

The following is a list of those groups or individuals that the Commission would like to thank for their special efforts in helping the Commission complete their task.

— Bus drivers Ken Watson and Ken Russell of Pacific Western Transportation. Their safe and courteous driving as well as their positive and energetic helpfulness were greatly appreciated during the province wide travel.

— Executive Council Office for the processing of accounts and expert advice on Administrative matters.

— John Lacusta of Government House for the use of the Boardroom for Commission Meetings.

— Department of Tourism for the use of their Boardroom for Commission Meetings.

— Denis Janvier of Treasury whose aid and advice on office space and furniture was invaluable.

— To all other departments whose selfless helping hands made our job easier.

The Rainbow Report: Our Vision for Health
Credits

a) **Three Volume Report**

Design and Illustrations: Karo Design Resources
Writer: Barbara Deters
Printer: Co-op Press Ltd.
Color Separations: The Graphic Edge
Photo Credits: (Shown on publication)

b) **The Video**

Produced by: The Image Works
Writer: Peter Adamski
Narrator: Michelle Armeneau-Burles

APPENDIX IV
CONTRIBUTORS

The following names are those individuals or organizations who contributed to the production of this report by sharing their ideas, thoughts and knowledge with the Commission. We have taken great care in preparing this list to ensure accuracy; however, should we have erred or omitted the listing of your name or organization, we apologize.

Confidential - 13
Anonymous Submissions - 24
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Adria, Ruth M.
Afaganis, Judy
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Albrechtsons, Barb
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Amyotte, Carol
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Anderson, Laural
Anderson, Leora
Anderson, Wilma
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Bahnuik, Cynthia (Mrs.)
Baier, Dianne (Ms.)
Bailey, F.E.
Bailie, Anna
Bakgaard, Evelyn
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Baldwin, Lisa
Balko, Lorraine
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Bannerman, Isabel
Barbeau, Marc
Barker, Mark
Barkun, Harvey (Dr.)
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Barson, W.
Bartlett, Cathie
Barton, Caroline (Mrs.)
Basara, Herta (Mrs.)
Basford, Linda
Baudistel, Leanne
Baxter, Dorothy (Mrs.)
Beaudet, Patricia
Beckedors, Brigita
Beckie, Ken B. & Helen
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Beller, Karen
Benn, Donna
Benn, Mavis
Bennett, Dean
Bennett, Sharlene R.
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Berg, Reinhard
Bergey, Valerie
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Bergman, Josie (Ms.)
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Bertok, Gertrude
Bertram, Jennifer & Ernie
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Besner, Jeanne
Betke, Irvine (Mr.), and household
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Biel, Roberta
Bieson, John
Bigelow, Shirley
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Birdsell, Judy
Bishop, Lorraine
Bjorgan, Ron
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Blaikie, Peter (Dr.)
Blair, Marlene
Blair, R.F. (Mr. & Mrs.)
Blair, Ray
Blais, Louise
Blessing, Dawn
Block, Harold & Marilyn
Boisvert, G.
Boisvert, P.E.
Bopp, Michael (Dr.)
Borkent, Barb
Bourke, Hazel
Bouthillier, Susan
Bowers, Alan
Bowker, Marjorie Montgomery (Judge)
Bowles, Wayne D.
Boyd, J. (Mrs.)
Bradley, J.E. (Dr.)
Bramwell, R.D. (Dr.)
Brandson, Wendy
Brasnett, Bill
Braul, Walter
Brennan, Kathy & Dennis
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Brooks, Marion (Czar)
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Bruha, Bi (Ms.)
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Buckley, Sheila
Buitendyk, Rita
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Bullfert, Alan
Burkhart, Edith B.
Burton, Betty
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Butler, Frank
Butler, R.E.
Butt, Else (Mrs.)
Buttars, Emma (Mrs.)
Bynuck, John
Byram, Joyce (Mrs.)
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Carlson, Fay
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Carney, Val
Carpenter, Margo
Carruthers, Peter (Mr.)
Carter, Kelly Anne
Carter-Edwards, Ernest
Cashman, Tony
Cassin, S.B. (Dr.)
Castagnero, Ricki
Caughlin, Lynda
Chaba, Bev
Chalifoux, Rose
Chan, Adam (Dr.)
Chervinski, Ab
Cherwoniak, Stephie (Mrs.)
Chiasson, Marie
Chipchura, Dave
Chocholacek, Joyce
Cholak, Rozanna
Chong, Alan (Dr.)
Chorney, Marilyn
Christensen, Evelyn
Christensen, Joel T.
Christie, Tom
Chunta, Andy
Clare, Louise (Mrs.)
Clark, Barbara
Clarke, Robert W.
Clarke, S.C.T.
Clarkson, Graham (Dr.)
Clausen, Margery
Clinto, M.
Cock, Denise
Cocks, Jack
Cocks, Marjorie
Cofell, Dean
Cofell, F.L. (Mrs.)
Cohen, Richard D. (Dr.)
Cole, Nayda
Connolly, Carol
Cook, Alice
Cook, Ben
Cook, Gisela (Ms.)
Cookson, T.S. (Dr.)
Cooper, Lois
Cordwell, Marjorie
Costuros, Carla
Cottell, Joanne
Covill, F.J. (Dr.)
Cowcill, Bob (Mr.)
Cowie, Marjorie
Cranfield, D.D.
Crighton, Maureen

APPENDIX IV

Crispin, F.
Crispin, T.
Croswell, Elizabeth
Crowley, Patrick (Dr.)
Croyne, Bill
Cruikshank, Peter
Cryderman, Paula
Culp, Annette
Cultis, Marg
Cumming, Brenda
Cummings, Margaret
Curr, C.J.
Currie, June (Ms.)
Curtis, Garry
Cusson, Randy
Cust, Karen
Czernick, Nettie R.
Czernick, Wilfred
D'Amico, Carol (Mrs.)
Dafoe, Vi
Dagenais, Bernard
Danyluk-Hall, Joanne
Davenport, Keith
Davidson, Karen Joan
Davies, Anne
Davies, Harvey
Davies-Fuhr, Arlene L.
Davis, Adelaide M.
Davis, Frances
Davison, Peggy (Mrs.)
Dawrant, Geoffrey (Dr.)
Dawson, Norman
Dawson, V.J. (Mr. & Mrs.)
Day, Gwen
Day, Jean
Day, R.A. (Mrs.)
Dayman, Muriel E.
de Cangas, Jose P.C.
de Groot, Nell
Dean, Colleen
Deane, Jeffrey J.
DeGroot, Linnie
Delehanty, Roslyn (Dr.)
Delorme, Tina
DeMille, Patricia
Denault, Chris
Denison, Ilene
DePaoli, Barbara
Deshayes, T.
Devries, Peter
Dickinson, Alfred H.
Didrikson, Garry J. (Dr.)
Dingwell, Karen
Doan, Leslie
Dobson, Munly (Ms.)
Doell, John
Doell, Kathy
Dollard, Sheila
Domeier, Beth (Mrs)
Donald, Claire F.
Dooley, Dorothy
Dorschied, Beverley
Doucet, Rose
Douglas, Alice
Dowell, Susan
Draper, N. (Mrs.)
Driscoll, A.J.
Driscoll, Flora E.
Driver, Doreen (Mrs. C.R.)
Driver, J.M.

Drysdale, Margaret Ann & Jim
Dubois, Lynne
Duce, Erlinda
Duff, Frank
Duffy, Fred
Duffy, Gloria
Duncan, Lynne (Ms.)
Dunn, Cathy
Dunn, Maureen
Dunphy, Marie Anne
Duplantie, Jean-Pierre (Mr.)
Durier-Copp, Martine (Dr.)
Durnatt, (Mr.)
Durrant, Dave
Dyck, Doris
Dyck, Elaine
Dyck, Norman & Margaret
Dykes, R.M. (Mrs.)
Dykstra, Jeff
Easingwood, Ervan (Miss)
Eddie, Heather
Edwards, Glen E. (Dr.)
Edwards, Jack L. (Dr.)
Ehret, Alberta
Eichmüller, Elisabeth (Mrs.)
Elder, Shirley
Eldred, Brian E.
Elliott, Rosemary
Emery, Rick
Emmons, Kevin
Enge, Reta
Enns, Carole (Mrs.)
Entz, Mary A.
Epp, Jake Hon.
Esper, George
Esslinger, Eleanor (Mrs.)
Estrin, Goldy
Evans, Delores
Evans, Jackie
Evans, John R.
Evans, Shirley A.
Evans, Stephen
Evjen, Clara
Ewasechko, Kirk (Dr.)
Fahmy, Nabil (Dr.)
Farr, Berva (Mrs.)
Fast, Hilda
Fauvel, O.R. (Mrs.)
Fedio, Jerry
Fedoruk, David
Fedoruk, Denise
Fehr, (Mrs.)
Ference, Lester
Ference, Sheila
Ferguson, K.
Fisher, Laureen
Fitzgerald, Esther
Fitzgerald, Kevin
Fjeld, Maureen
Flanagan, Kerstin
Fletcher, Betty
Flood, Brian
Flood, Shawn (Mr. & Mrs.)
Fofonoff, Doreen
Fok, Bernard
Fontaine, Joan
Forbes, Evelyne
Forbes, Shirley E.
Forsyth, Maureen (Mrs.)

Fortier, George
Foster, Betty
Fowler, P.
Fralick, Kathleen
Frank, Flo
Frank, Harold
Francescutti, Louis H. (Dr.)
Fraser, Georgina
Freedman, Joe
Freeman, Laura (Ms.)
French, Alice
Frick, Corine (Ms.)
Friese, P. (Mrs.)
Friesen, Melanie
Frinskie, Karen
Fritz, Sigrid
Fry, Anne
Fuhr, V.
Fullerton, Arni
Funk, Fred
Furber, Ruby
Fyke, Ken (Mr.)
Gahan, T.
Gainer, C. Jane (Dr.)
Gainor, Lorrie A.
Galibois, Paul
Gallant, Camille (Mr.)
Gallup, Kelly
Gammon, Michael L. (Dr.)
Gardiner, Leslie
Garsonnin, Dan
Gartner, Joseph
Gates, Linda
Gattiker, Urs E.
Gaunce, Ron
Gaunt, Philip
Gauthier, Sylvie
Geddert, Mary K.
Gelfand, Elliott T. (Dr.)
Gemmell, Nellie
Geurts, Michelle
Gibbons, Mike
Gibson, Marjorie M.
Giesbrecht, Marion R. (Mrs.)
Giese, Ann
Giffin, Eleanor (Ms.)
Gifford, Michael
Gilchrist, Marilyn
Gilliland, Marie
Gingras, Gustave (Dr.)
Girard, Joseph P.
Girardin, Gladys
Glasier, B.A.
Glass, Gordon
Glass, Helen (Dr.)
Glass, Susan
Goebel, A.E.
Golden, Jean (Sister)
Goldsand, Judith (Mrs.)
Goodjohn, Gail
Goodridge, Glen
Gordon, Patricia (Mrs.)
Gorman, Llano
Gough, K.H. (Dr.)
Gould, N.
Grady, Wayne (Mr.)
Graff, Nana
Grams, Judy
Grams, Larry
Grandish, Brian & Leanne

Grant, Colin M.
Grant, Ethel
Grav, Ella
Grav, Ottar
Graves, Warren
Green, Lou
Greenwood, Robert
Grey, Melva
Grier, Maureen L.
Griffin, G.
Griffith, Fred (Mr.)
Grisdale, Lloyd C. (Dr.)
Grosvenor, William
Grue, Karen Jo
Gudmundson, Brian (Mr.)
Guengerich, Mary
Guenter, Clarence A. (Dr.)
Guidotti, Tee L. (Dr.)
Guigon, Gilbert
Guild, Brian
Guillemin, Evelyn
Gusse, Adele (Mrs.)
Gusse, Larry (Mr.)
Guthrie, L.
Gyorkos, Doreen M. (Mrs.)
Haddad, William J. (The Honourable)
Haines, Margaret
Halas, S.
Hale, Lois (Ms.)
Hall, Dennis (Dr. & Mrs.)
Hall, Emmett (Justice)
Hall, Gwen (Mrs.)
Hall, Patricia
Hall, Terry (Ms.)
Hall-Petry, E. (Mrs.)
Haltyn, G.
Hamilton, Norah
Hamlin, Sheila
Hamm, R. Douglas (Dr.)
Hanegan, Don & Mildred
Hanlan, Margaret (Mrs.)
Hanna, J.D.
Hansen, Elaine
Harbourne, Bob
Harcus, Ken
Hardy, Leslie K. (Dr.)
Harle, Gerry (Dr.)
Harris, Elsie I.
Harris, Raymond
Harrison, Linda
Hart, Richard
Hasan, Shaukat (Dr.)
Haskins, Peter
Hastings, Cora J.
Hatch, L.R. (Dr.)
Hatfield, C.B. (Dr.)
Hatfield, Walter
Hatton, Russell (Rev.)
Hauk, Peggy L.
Hawrelak, Thomas
Haykowski, Ed
Haynes, Bill
Hays, Helen (Dr.)
Hazlett, C.B. (Dr.)
Heater, Mae
Heidemann, Elma G.
Hein, Sophie
Helmers, D.H.
Helmsing, Hewitt (Mr.)

APPENDIX IV

Henkel, Laura (Mrs.)
Hennig, Frieda
Henry, G. (Mrs.)
Henry, Sheila
Hensel, Gordon J.P. (Dr.)
Heuchert, Carol Ann
Hewes, Bettie
Hidson-Lewis, Rhonda
Hiebert, Edie
Hiebert, Leila
Higgins, G.L. (Dr.)
Hillstrom, Margaret
Hillstrom, Stanley
Hinde, Donna B. (Ms.)
Hingley, Shirley
Hingston, R.E. (Bob)
Hiscock, Bob (Mr.)
Hnatiuk, Susan
Hobbs, Eileen M.
Hodgins, Kenneth W. (Mr.)
Hoffert, Yvonne
Hoffmeyer, Chery Ann
Holland, Joan
Holliday, John R.
Holmstrom, Andrea
Holtz, Klaus
Horne, Kathy (Dr.)
Horney, Verna
Hosack, Audrey
Hough, L.V.
House, John
Howes, Diane
Hrubizna, Lynda
Hudy, S. (Dr.)
Hughes, Juanita
Hullock, June
Humble, Iris
Hunter, Beverly
Hunter, John F. (Dr.)
Huraj, Pat
Husband, Allison
Hyde, Harry (Dr.)
Hykawy, Nick
Ingram, Pat Ms.
Ireland, Jean M.
Ireland, Linda
Irving, Kim
Irwin, Patrick J.
Isaac, Edith
Isbister, Pat (Mrs.)
Isinger, Len
Ison, K.V.
Jackson, Dorothy
Jackson, Eleanor
Jackson, F.I. (Dr.)
Jackson, Walter
Jacobsen, Chris
Jacobson, Carolyn
Jacobson, Doug L.
Jacobson, J. Robert (Bishop)
Jager-Hofer, Don
Jah, Ella
Jahn, Karen
James, Wendy
Jameson, Judy
Jansen, Leon (Brother)
Jardine, B.
Jenkins, Joy
Jense, Art J.
Jeske, Otto

Johns, Eva R.
Johnston, Barbara
Johnston, Pat
Johnston, Rosemarie
Johnston, Terry L.
Jones, Allyce
Jones, Bernice E.
Jones, Geraldine G. (Mrs.)
Jones, Glenda E.
Jones, Pat (Ms.)
Jorawsky, Laura (Mrs.)
Joss, Floyd D. (Dr.)
Jowett, Tom
Juchli, Andre
Junk, D. (Mr.)
Juurlink, Bonnie C.
Kamitomo, Valerie (Ms.)
Kane-Upton, Kathryn
Karpman, Shelby (Dr.)
Karsten, Margaret
Keating, Joyce
Keller, Diane
Kelly, Maureen
Kelly, Sharon
Kemp, Ruth
Kempinsky, Dorothy
Kennedy, Kathryn
Kenney, Mark
Kent, Aileen M.
Kenzie, Martin
Keohane, Kathleen
Kerr, Geraldine
Kientopp, William
Kieran, Marilyn
Kinasewich, Bob
King, Clare (Ms.)
King, Gordon G.
King, Pam
King-Hunter, Edna
Kinnie-Steeves, Angela
Kirker, Janis
Kirkpatrick, Margo
Klassen, B.
Klaver, Susan A.
Kleeberger, Bruce G. (Dr.)
Klein, Diane
Kleysen, Wayne H.
Klinke, W. Peter (Dr.)
Kneller, Rudy (Mr. & Mrs.)
Knowler, A.S. (Bert)
Knudslien, Cecil
Koch, Helmut G. (Dr.)
Koehle, Albert
Koehle, Nuria
Koltun, B.
Konkin Van Es, Kathleen
Kostelyk, Mary-Ann
Kotow, Elaine
Kovich, P. (Ms.)
Kozak, Bernard
Koziol, David
Krawiec, Marlene
Kreamer, Heather (Mrs.)
Krieg, Maria
Kristensen, John
Krug, A.T. (Mrs.)
Kubicek, L.
Kucheran, Jack
Kumar-Misir, Victor (Dr.)
Kur, John R.

Kurian, Nirmala (Dr.)
Kurtz, Maureen (Mrs.)
Kurylo, Anna
Labelle, Glenda
Labentsoff, Lucy
Lachance, Barbara (Mrs.)
Lai, Vivian (Ms.)
Lambert, Ruth
Lang, Les
Lang, Maurice
Lantz, Eve
Larsen, Maureen
Larson, Terry
Laucher, Frank & Ann
Laurie, David & Joan (Mr. & Mrs.)
Laurie, Janice
Lawrence, Patrick
Layton, Anne and family
Lazaruk, Mary
Le Mesurier, Pearl
LeBlanc, Rheal (Mr.)
LeBlanc, Walter
Leclerc, Denise (Ms.)
Leiford, Rennie
Leitch, Lorne C.
Lema, Rose
LeNavenec, Carole-Lynne
Lennie, Oryssia (Ms.)
Lennox, Lynn (Ms.)
Leonard, Kathleen (Mrs.)
LePage, Gilles (Mr.)
Leslie, Emily
Letourneau, Susan (Dr.)
Lewis, Gail
Li, De-juan
Lien, Violet
Liepert, Ron
Link, Erna (Mrs.)
Litchfield, Reid
Littlejohns, D.G. (Rev.)
Loewen, Marion F.
Losie, Carol F. (Ms.)
Loucks, Alice
Louie, Thomas J. (Dr.)
Love, Holly (Ms.)
Lowe, Cynthia
Lucas, Elsie
Lucas, Terry
Lucier, Esther
Luckhurst, G. (Dr.)
Lukasewycz, M.
Lusson, M. Henri
Luu, Ky
Lyford, Geoffrey
Maack, Friedrich
Maberley, G.A.
Mably, Don
Macdonald, Diana
MacDonald, Fay
MacDonald, R. Neil (Dr.)
MacDougall, Marlene
MacEachern, Grant
MacKay, J.A. (Dr.)
Mackenzie, R.M. (Dr.)
MacKinnon, Betty
MacKinnon, Don
MacLean, Anita
MacLean, Dwina E.
Macleay, Doug

Macmillan, Ian (Rev.)
MacNeil, Edward (Mr.)
Mahe, Crystal
Maisonneuve, Emile J.
Majors, Leslie (Ms.)
Male, D.E.
Malek, Dave
Maloney, Jeanne
Mangal, Indira
Manion, June (Mrs.)
Manning, Ruth
Manson, Raymond
Mansour, Greta (Dr.)
March, Bev. S. (Mr.)
Mark, Ken
Marko, Nick
Marks, Brenda
Marks, Patrick B.
Marliss, Ethel
Maroes, Eleanor
Marshall, Bev
Marshall, Sharon (Ms.)
Marshall, Victor (Dr.)
Martin, J.
Martin, Jean-Claude
Martin, Sharon
Martinello, B.P. (Dr.)
Maskalyk, Lucille
Matus, Sue
Mayer, John W.
Mayer, Theresa
McArthur, Robert G. (Dr.)
McCallum, Carol (Mrs.)
McConnell, Fleming (Dr.)
McCorquodale, May
McCullagh, Larry
McCulloch, Melverine
McDowell, Hazel
McEachern, P.S.
McEwan, Corrine
McFalls, W.J.
McFarlane, Chris
McFaul, Preston
McGee, Bill
McGregor, Diane
McGregor, Ken
McGuire, Glen
McHugh, Alice (Mrs.)
McInnes, Flora
McInroy, Maureen
McIntosh, Jean
McIntosh, Mary
McIver, Jessie
McKeen, Duncan
McKelvey, Neil (Mr.)
McKendrick, Patricia (Mrs.)
McLaren, Irene
McLaughlin, Victor (Dr.)
McLean, Joan
McLeod, Harvey
McLeod, Sharon
McManus, Ralph N. (Dr.)
McMullen, Carrie (Ms.)
McMurtry, R.Y. (Dr.)
McNally, Corinne
McNeely, Susan
McPherson, Gary
Medd, Sharon
Meekison, Pat
Meijer, Gerrit & Anna

APPENDIX IV

Meldrum, Arlene
Mercier, Jean (Mr.)
Merkler, Gloria
Messier, Mary Rose
Messner, Ruth (Mrs.)
Meyer, Jack L.
Michaels, Ruth
Mielke, Marjorie
Mighton, D.S. (Mr. & Mrs.)
Mihalchan, Jen
Miller, Donna
Miller, Joe
Miller, Mildred (Mrs.)
Milligan, John (Mr. & Mrs.)
Milne, E. (Mrs.)
Milne, Lucy I.M.
Milner, Macey (Dr.)
Milton, Earl R. (Dr.)
Miner, Donald
Mirau, Heather
Mirtha, Catherine
Mitchell, Shirley
Moen, Ernie (Mr.)
Moffat, Doug (Rev.)
Molloy, D.W. (Dr.)
Molnar, George D. (Dr.)
Monkman, Catherine
Montgomery, R.L. (Mr.)
Moonie, George T. & Doris M. (Dr. & Mrs.)
Moore, Vera (Mrs.)
Moore, Winnie (Mrs.)
Morf, Bill
Morgan, Chris
Morgan, Diane
Morgan, K. Vera
Morgan, Margo
Morgan, R.A. (Dr.)
Morical, Dale
Morical, Priscilla
Morris, Claire (Ms.)
Morrison, Connie
Morrison, Donna
Morrison, Harold L.
Morrison, Tim
Morrison, Trudy
Mowat, (Mrs.)
Mrochuk, T.
Mullane, Kathleen
Mullen, W. Edgar (Rev.)
Munro, Sharon
Murphy, Deirdre (Dr.)
Murray, John R.
Murray, Judith
Murray, Robert (Dr.)
Mustard, Fraser J. (Dr.)
Mydland, W.E. (Dr.)
Myren, Joan (Mrs.)
Nafe, Margaret
Nagy, Marie
Naslund, Debra
Nedved, Rita
Neill, Sylvia
Nelson, Anna (Mrs.)
Nelson, Joan
Nelson, Ruben (Mr.)
Netterville, Joy
Neuman, Judy
Neumeier, Janice
Newton, Anthony
Nicholson, Dave (Mr.)
Nielson, Linden
Noble, L. Marvelle
Nodwell, Maureen (Mrs.)
Nordgaard, Karen
Noseworthy, Thomas Wm. (Dr.)
Notland, Lillian
Nott, Robert
Nowicki, Julian (Mr.)
O'Brien, Al (Mr.)
O'Callaghan, J.P.
O'Coin, Connie
O'Coin, Dwayne
O'Malley, Kathleen A.
Oke, David (Mr.)
Olenek, D.C.
Olsen, Dale A.
Olsen, Sheralee (Mrs.)
Olson, Marcia
Orieux, Collette
Orr, Mary
Orr, William
Orsborn, David (Mr.)
Osler, W.E. (Mrs.)
Oslie, Muriel
Oss-cech, Ludwig
Oswin, R.F. (Dr.)
Oszust, Nancy
Oxamitny, Pauline
Pabst, Henry F. (Dr.)
Packer, Anne
Paetkau, Margaret E. (Dr.)
Page, Ellen
Palma, Peter
Panton, David
Paradis, Annette
Paranich, Darrell (Mr.)
Parkin, Leonard
Parlee, Pauline (Mrs.)
Patel, Jini
Patterson, Eileen
Patton, Myra
Paul, Harriet
Pauley, Rosemary
Pawluk, Margaret
Peckham, Lois
Peddlesden, Jennifer
Penner, Barbara
Pennington, Ruth M. (Mrs.)
Pepler, Marg.
Peregrym, Judy
Perrin, Magdalene
Perrott, Joan
Perry, David
Petruschuk, Helen
Pettit, Rita B. (Mrs.)
Pettyjohn, Keith & Carol
Pham, Michael
Philippon, Don (Dr.)
Phillips, Karen
Phillips, Violet
Philpott, Pamela
Pilot, Ellen
Pilson, Mary Brigid
Pincock, Gordon
Pipe, Andrew (Dr.)
Pitt, Marilyn
Pittis, Glenalda (Ms.)
Plant, Arlene
Plausteiner, Bruce
Plaza, Frank J.
Pliske, A.M.
Podiluk, Walter (Mr.)
Poirier, Eveline
Pollock, Brenda
Polushin, M. (Dr.)
Poohkay, Alice M.
Porter, Cathy
Potier, Paul A.
Pratt, Corinne
Pratt, Jim
Pratt, Kathleen
Pratt, Richard
Prefontaine, Louise
Prince, James R. (Dr.)
Pritchard, Elaine
Prybylski, William
Ptycia, Mary
Pulliam, Norman
Qaiser, Sagid (Dr.)
Querengesser, Beth (Mrs.)
Quinn, Ken
Rach, Diane
Rachinsky, Pearl
Rad, Wilma (Mrs.)
Radomsky, Mary
Radostits, Ivan & Mary Agnes
Raduenz, Louise (Ms.)
Ragan, Nancy
Randle, Dorothy
Rankin, James A.
Rausch, Carl
Rebstock, Paula
Reddington, J. Lloyd (Dr.)
Reed, Dawn
Reedyk, Martin (Dr.)
Rees, Maria
Regan, Tom (Mr.)
Regier, Elsie
Reich, Carl J. (Dr.)
Reid, E. Marjorie
Reid, Earl (Mr.)
Reid, Elma (Ms.)
Reid, Ian (Dr.)
Reimer, Karen
Reinders, Harry
Reiswig, Harold
Remmick, John
Rempel, Else E.
Remple, Stan (Dr.)
Renouf, Brian
Revee, Joan
Reynolds, C. (Mrs.)
Reynolds, Linda
Rideout, Sterling (Mr.)
Riediger, David
Riley, Caron
Rinas, Ruth
Ringrose, C.A. Douglas (Dr.)
Risbud, Sheila
Ritter, John
Roberts, William (Rev.)
Robertshaw, Conne (Dr.)
Robertson, Charlene M.T. (Dr.)
Robertson, Ken
Robinson, Brian and Judy
Rochford, Veronica Marie
Rockwell, F.S. (Dr.)
Roe, Louise (Mrs.)
Roellchen-Pfohl, Joan
Rogerson, William
Romanow, Ron
Romanow, Sharon (Mrs.)
Romanowski, Barbara (Dr.)
Ronca, Margaret (Mrs.)
Roper, Elsa
Rosadiuk, Susan
Ross, Cathy
Rossall, Joan
Roth, Idel
Roth, Linda
Roth, Michael
Rowand, Scott (Mr.)
Rowe, Betty Ann (Mrs.)
Roy, Sylvie
Ruff, Jack A.
Russell, J. B. (Mrs.)
Russell, Kelvin J. (Dr.)
Rutherford, Lillian J.
Ruttan, Vern
Ryan, Sandra
Sabo, Margaret
Sadoway, Jody
Sagar, Seline
Samletzki, K.
Samletzki, L.
Samol, Mila
Sanchez, Wendy (Ms.)
Sanders, Derek
Sands, E.W.A. (Dr.)
Sanregret, Anne
Sarver, Bridget
Saunders, S.
Savage, J.R. (Dr.)
Saville, Gerry (Ms.)
Saxena, Inge H.
Schalk, John
Schattschneider, Hazel
Schawalder, Leah
Schlingerman, Sue (Ms.)
Schmidt, Bryan
Schroder, Marty (Mr.)
Schubert, Jill (Ms.)
Schuler, Sonya
Schultz, E.
Schumacher, Barb
Schurek, Lois
Schwab, Sarah
Scott, Michelle M.
Scott, Sherry (Mrs.)
Scraba, Maureen
Scully, Hugh (Dr.)
Searce, Lloyd (Mr.)
Seberg, Myha
Seeber, Bobby (Mr.)
Sekhon, Awatar S. (Dr.)
Selwood, Christine
Semeniuk, Ray (Mr.)
Severinson Thompson, Debbie
Severs, Bill
Severson, Jean
Sexty, Doreen
Shanks, Darlene
Shaw, Diane
Shaw, Emily
Shaw, W.B. (Mrs.)

APPENDIX IV

Shaw, Wayne (Mr.)
Sheppard, W.
Sherlock, F. John
Sherlock, Marjorie
Shewchuk, Dawn (Ms.)
Shields, Eunice (Mrs.)
Shifflett, D.M. (Mrs. Betty)
Shipstone, Asheesh (Dr.)
Shirley, Phil H.
Shone, Margaret A.
Shortt, R. Wayne (Rev.)
Shtabsky, Aaron
Shurgelo, Chris
Siega, Catherine
Siega, Levy (Mr.)
Siega, Pat (Mr.)
Silbernagel, Myrtle
Sime, Phyllis
Simons, Alfred
Simpson, Elizabeth
Sinclair, Ann
Sine, Madonna (Mrs.)
Skaken, Ross (Dr.)
Skaken, Sennoi (Dr.)
Skalicky, Randy
Skelton, David (Dr.)
Slevinsky, Hank
Sloan, T. Ivan (Dr.)
Smid, Ivy
Smith, Alan F.
Smith, Bettymay
Smith, D.
Smith, Donald F. (Dr.)
Smith, Eldon R. (Dr.)
Smith, Ella
Smith, Heather
Smith, Joyce
Smith, Ruth (Mrs.)
Smith, Susan E.
Smith, Warren
Smoole, Norma M.
Smyth, Cyril (Mr.)
Snedden, J.H. (Dr.)
Snider, Douglas G. (Dr.)
Sorenson, Ruby
Soubliere, Jacques
Spady, Donald W. (Dr.)
Speer, Margaret
Spencer, Miles E.
Spencer, Nora
Spielman, G. (Mrs.)
Spika, Inge
Sproule, Janice
St. Dennis, Myrna
St. Godard, A.
St. Godard, Leo
St. Hilaire, Dorothy
Stainton, Colleen (Dr.)
Stamm, Ben
Stamm, E. Jean (Mrs.)
Stanley, Vicki
Steadman, (Mrs.)
Steffler, Doug
Stein, Gary
Stelter, Carolyn
Sterr, Ruby
Stevens, Jocelyn (Ms.)
Stewart, Ann
Stewart, Carol
Stewart, Carrol
Stinson, Shirley (Dr.)
Stirling, Glenn C. (Dr.)
Stirling, Phil (Mrs.)
Stokes, Carol
Stollery, R.
Stone, David
Stone, Martin
Stone, Pat (Ms.)
Stonhouse, Emily
Stonhouse, Philip
Storoz, Linda L. (Dr.)
Strachan, P.
Street, Diane
Strom, Martha
Sugden, Scott G.
Sullivan, Elsie M.
Summers, Laurie A.
Sutton, Audrey
Sveinson, Helen
Sveinson, Tom
Swanson, Gary E. (Dr.)
Swanson, Judy
Swanson, Rudy (Mr.)
Swedberg, Paul M.
Swinermer, Harold
Sylvie, Roy
Symic, Lorna
Taje, Terry
Tatarewicz, Paul
Taylor, Alan H.
Taylor, Joanne
Taylor, Lucy & Bill
Temple, Laurel
Terry, A.L.
Tertzakian, Gerard (Dr.)
Tetreault, Leo J.
Then, Karen
Thiessen, A.E. (Dr.)
Thomas, A.E. (Mrs.)
Thomas, Ken
Thompson, Derrick (Dr.)
Thompson, MaryBelle (Mrs.)
Thomson, Allistar (Mr.)
Thomson, Doris V.
Thomson, Joyce
Threinen, Maria
Thumlert, Ron
Thurston, H.A.
Tigner, Mary
Titford, Cecily
Tkach, Kathy
Toal, Kevin (Dr.)
Tobert, Marian
Tobias, E. (Betty)
Toews, Laurie
Toews, Linda (Mrs.)
Tomnuk, Roger
Tomym, Lillian
Tondu, Elizabeth
Tooley, Michael Patrick
Tough, Rick
Trautman, Ed & Lena
Traves, Linda
Travis, Cecil R.
Travis, Una H.V.
Trelford, John
Trenchuk, Eugene (Mrs.)
Trendel, Brian W.
Trew, Marsha (Dr.)
Tripp, Marjorie
Trogen, Gary (Mr.)
Try, Rose
Tullin, Sandy
Tumbach, Karen
Turnbull, Martha
Turner, Clyne (Dr.)
Turner, Helen (Mrs.)
Turner, James F.
Turton, Laurel
Tutt, George
Tuttle, M.J. (Dr.)
Tweten, M.
Tymchuk, Jean
Ulfstem, Paul
Underhill, Mary
Undershultz, Shirley & Lorne
Unser, Pearl (Mrs.)
Urano, M. Miss
Valdvogl, L.
Valentine, Brian
Van Bostelen, Peter (Dr.)
Van Bostelen, Sonja
Van Haitsma, Sylvia
Van Leusden, R.
Van Moorsel, Connie
Van Overloop, Linda
Van Wiebe, H. (Mr.)
Van Wiebe, May (Mrs.)
Vance, Cyndi
Vandermeer, Bernie
Vanderschaaf, Terry
Vanderveen, Ed
Vanhooren, Gerry
Vard, Cathy
Vaz, Jerry (Dr.)
Veleti, Mary
Vickers, Marian G.
Vigar, Barbara A.
Vipond, Alison
Vipond, Pamela
Volmer, Natalie
Vooys, Jeanette
Voss, Maria
Wahl, Joe
Wakefield, Mildred
Walcott, Tedd R.P. (Dr.)
Walkemeyer, H.C.
Walker, Alice
Walker, Helen (Mrs.)
Walker, K. Frank
Walker, Richard E. (Dr.)
Wall, Katherine (Mrs.)
Wallace, Anna
Warawa, David
Warke, Trevor Nelson (Mr.)
Warren, Marge (Mrs.)
Wasylenchuk, RoseMarie (Mrs.)
Wasylysyn, Sophia (Mrs.)
Watanabe, M. (Dr.)
Watson, Joan (Ms.)
Watson, Muriel R.
Watt, Kathleen
Watts, H.R. (Dr.)
Webber, Hennie (Mrs.)
Weder, Robert
Weir, Esther (Mrs.)
Weistra, Eddy
Wells, Gordon (Mrs.)
Welsh, Eva
Werstiuk, Wendy & Brad
West, T. Joy
Westbury, Marilyn (Dr.)
Westgeest, Nicolas
White, Barbara J. (Ms.)
White, George (Mr.)
White, Linda
White, Vernon L. (Mr.)
Whiteley, Jessie (Mrs.)
Whitfield, Warren
Whitfield, Yvonne
Whitlock, Penny (Mrs.)
Whittall, Alan
Whittall, Geoff
Wianko, K.B. (Dr.)
Wiebe, Jake
Wiesmantel, Edna (Mrs.)
Wildgoose, G. Norman.
Wilke, A.A. (Dr.)
Wilkinson, Bruce
Wilkinson, P.R. (Dr.)
Willett, Vernon
Williams, Jennifer
Williams, Marilyn
Williams, Vera
Willier, Russell
Wilson, Douglas (Dr.)
Wilson, E.D.
Wilson, Georgena
Wilson, L.
Wilton, John
Wilton, William C. (Mr.)
Wingrove, Hazel R.
Winkelaar, Philip G. (Dr.)
Winspear, Martin
Winter, Beatrice & Keith
Winter, Jean (Mrs.)
Winter, R. W. (Dr.)
Wiseman, Mary
Wohlgemuth, Lorna E.
Wolczuk, Patricia (Dr.)
Wolfe, Marilyn
Wolfleger, Kathy
Wolstenholme, James (Mr.)
Wong, Ken
Wood, Gladys
Wood, Gregory
Woodburn, Bev
Wright, June R. (Mrs.)
Wright, Karyl (Ms.)
Wyllie, Norma
Wynnyk, Joan
Wynnyk, Larry (Mr.)
Yarmey, Moreen (Mrs.)
Yates, B. Patricia
Yates, Grace
Yeates, Glenda (Ms.)
Youb, Bruce
Young, Jack & Irma (Dr. & Mrs.)
Young, Robin
Young, Susan
Youngs, Doreen & Walt
Youzwishen, Odette
Yukes, Anne
Yurkiw, Henrietta
Zak, Mary
Zimmerman, Mearl
Zon, Lorne (Mr.)
Zurch, Rose

APPENDIX IV

A Centre for Women, Planning Committee
Access Network, The Alberta Educational Communications Corporation
Action on Smoking and Health
Ad Hoc Committee on Guidelines for Home Ventilators
AIDS Network of Edmonton Society
Alberta Advisory Council on Women's Issues
Alberta Alcohol and Drug Abuse Commission
Alberta Ambulance Operators Association
Alberta and North Synod, Evangelical Lutheran Church in Canada
The Alberta Association of Homemaker Services
Alberta Association of Midwives
Alberta Association of Municipal Districts & Counties
Alberta Association of Naturopathic Practitioners
Alberta Association of Optometrists
Alberta Association of Orthotists & Prosthetists
Alberta Association of Registered Nurses
Alberta Association of Registered Occupational Therapists
Alberta Association of Social Workers
Alberta Association on Gerontology
Alberta Cancer Board
Alberta Catholic Hospitals Foundation
Alberta Children's Hospital Child Health Centre, Calgary
Alberta Coalition for Universal Health Care
Alberta College of Remedial Herbalists Association
Alberta Community Health Nurses Society
Alberta Council on Aging
Alberta Dental Association
Alberta Dental Hygienists' Association
Alberta Drug Review and Utilization Group
Alberta East Central Health Unit
Alberta Education
Alberta Federation of Labour Workers Health Centre
Alberta Foundation for Nursing Research
Alberta Friends of Schizophrenics
Alberta Gerontological Nurses Association, Central District
Alberta Guild of Ophthalmic Dispensers
Alberta Health
Alberta Health Disciplines Board
Alberta Heart and Stroke Foundation
Alberta Heritage Foundation for Medical Research
Alberta Hospital Association
Alberta Interfaith Coalition on Aging
Alberta Law Reform Institute
Alberta Long Term Care Association
Alberta Massage Therapists Association
Alberta Medical Association
Alberta Mental Health Nurses Interest Group
Alberta Midwifery Task Force
Alberta Migraine Assistance Association
Alberta Multicultural Commission
Alberta Nursing Education Administrators
Alberta Occupational Health and Safety Council
Alberta Occupational Health Society, Public Policy Committee
Alberta Palliative Care Network
Alberta Pastoral Care Association
Alberta Pharmaceutical Association
Alberta Physiatry Association
Alberta Physiotherapy Association
Alberta Podiatry Association
Alberta Public Health Association
Alberta Recreation and Parks
Alberta Registered Dietitians Association
Alberta Retired Public Employees Society
Alberta Roman Catholic Bishops' Conference
Alberta School Trustees' Association
Alberta Senior Citizens' Homes Association
Alberta Seniors Dental Plan Committee
Alberta Society of Orthopaedic Surgeons
Alberta Society of Public Health Dentists
Alberta Society of the Friends of Medicare
Alberta Status of Women Action Committee (Edmonton Working Women)
Alberta Teachers' Association
Alberta Union of Provincial Employees
Alberta Union of Provincial Employees, Local 002
Alberta Urban Municipalities Association
Alberta Women's Institute
Alzheimer Society of Edmonton
Amyotrophic Lateral Sclerosis Society of Alberta, Northern Alberta Chapter
Association for Residence Maintenance for Seniors
Association for Shared Childbirth
Association of Salvadoran Refugee Doctors of Alberta
Astra Pharma Inc.
Athabasca Health Unit
Banff Planned Parenthood
Baptist Committee on Public Life
Bethany Care Centre Calgary
Bethany Nursing Home and Auxiliary Hospital, Camrose
Big Country Health Unit
Blackfalds Cheemo Club
Blue Cross
Bow Cliff Seniors
Bow Island Health Centre Auxiliary
Bow Island Health Centre Board
Bow Island Health Centre, Nursing Administration
Bow Island Health Centre, Staff Nurses
Bowlen Technical Management Services
Boyle-McCauley Health Centre
Brooks Health Centre
Calgary Area Hospital Advisory Council
Calgary Association of Self Help
Calgary Birth Control Association
Calgary Board of Health
Calgary Chamber of Commerce
Calgary District Hospital Group, Board of Trustees
Calgary Hospitals' Development Association
Calgary Orthotic-Prosthetic Services Ltd.
Calgary Regional Mental Health Council
Calgary Regional Psychiatric Services Planning Committee
Calgary Roman Catholic Separate School District I/Further Education Centre
Camp He Ho Ha, Board of Directors
Camrose and District Retired Teachers' Association
Canadian Bar Association, Alberta Branch, Health Law Section
Canadian Bar Association, Alberta Branch, Special Project Committee
Canadian College of Health Service Executives, The Alberta Chapters
Canadian Council of the Blind, Medicine Hat Club
Canadian Diabetes Association, Alberta Division
Canadian Distance Learning Development Centre
Canadian Drug Manufacturers Association
Canadian Institute of Public Health Inspectors, Alberta Branch
Canadian Mental Health Association, Alberta Division
Canadian Mental Health Association, Alberta South Central Region, 1988
Canadian Organization of Small Business, Inc. In Co-operation with Dr. John W. Markham
Canadian Parks/Recreation Association
Canadian Red Cross Society
Canadian Society for the Prevention of Cruelty to Children
Canadian Society of Hospital Pharmacists, Alberta Branch
Canadian Tax Foundation
Canadian Union of Public Employees (Alberta Division)
Catholic Health Association of Alberta
Catholic Women's League of Canada
Central Alberta Psychiatric Planning Committee

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Central Northeast Edmonton Hospital Committee
Cerebral Palsy Association In Alberta
Charles Camsell Provincial General Hospital
Chase and District Health Society, Chase, B.C.
Child and Adolescent Services Association, Parents' Support Group
Chinese Medicine and Acupuncture Association of Canada
Chinook Health Unit Board
Chiropractic Patients Association of Alberta, Edmonton Branch
City of Edmonton, Social Services Advisory Committee
City of Lethbridge Health Unit
City of Medicine Hat, Day Care Services
Claresholm General Hospital District No. 24
College of Chiropractors of Alberta
College of Family Physicians of Canada, Alberta Chapter
College of Physical Therapists of Alberta
College of Physicians and Surgeons of Alberta
Community Resource Centre, Medicine Hat
Consumers' Association of Canada (Alberta)
Council of Teaching Hospitals of Alberta
Denturist Society of Alberta
Drumheller Health Unit Board
Easter Seal Ability Council
Edmonton & District Nursing Administrators Committee
Edmonton and Rural Auxiliary Hospital and Nursing Home District No. 24
Edmonton and Rural Auxiliary Hospital and Nursing Home District No. 24 Central Assessment and Placement Service
Edmonton Area Hospital Fund Development Representatives
Edmonton Board of Health
Edmonton Board of Health Staff Nurses Association
Edmonton Hard of Hearing Association for Adults
Edmonton Nursing Services
Edmonton Psychiatric Services Planning Committee
Edmonton Regional Mental Health Council
Edmonton Social Planning Council
Edmonton Vaginal Birth after Cesarean Support Association
Executive Nurses Association of Alberta
Extendicare Health Services Inc.
Extendicare/Leduc
Family and Community Support Services Association of Alberta
Family and Community Support Services, Athabasca and Area
Family and Community Support Services, City of Drumheller
Family and Community Support Services, City of Medicine Hat Advisory Board
Family and Community Support Services, Lacombe and District
Family and Community Support Services, Spruce Grove
Family and Community Support Services, Vegreville
Fédération des Femmes Canadiennes Françaises, Section de St. Isidore
Federation of Medical Women of Canada
Federation of Medical Women, Alberta Chapter (Calgary)
Foothills Health Consultants
Foothills Provincial General Hospital, Board of Management
Fort McMurray Personal Support Network
Fort McMurray Regional Hospital Foundation
Fort Saskatchewan General Hospital Board
Fort Saskatchewan Seniors Advisory Board
Four Worlds Health Promotion Program
Freedom From Fear Foundation in Alberta
Galahad Health Care Centre
Galahad Health Care Centre Nurses and Nursing Assistants
General Hospital (Grey Nuns) of Edmonton
Gimbel Eye Centre, Calgary
Glenrose Rehabilitation Hospital
Good Samaritan Society, Edmonton
Goodwill Rehabilitation Services of Alberta
Grant MacEwan Community College, Social Policy Class
Hanna & District Mental Health Council
Head Injured Re-learning Society (Calgary)
Health Action Network Society
Health Sciences Association of Alberta
Health Unit Association of Alberta
Healthy City Association, Calgary
Heart Health Task Committee
High River and Auxiliary General Hospital and Nursing Home District No. 11
Hinton General Hospital
Holistic Health Promotion Group
Holistic Nursing Interest Group of Calgary
Hospital Occupational Health Nurses
Income Security Action Committee
Independent Physical Therapists of Alberta
Indian Association of Alberta
Institute for Health Care Facilities of the Future
Insurance Bureau of Canada
Kerby Centre
Kopsicum Health & Vitality Centre
La Crete and Area Concerned Citizens Group
Learning Disabilities Association of Alberta
Leduc Senior Citizen Steering Committee
Leduc-Strathcona Health Unit
Lethbridge & District Pro-Life Association
Lethbridge Housing Authority
Lethbridge Interagency Group Concerned with Gaps in Services to Brain-injured
Lethbridge Regional Mental Health Council
Little Bow Auxiliary Hospital District No. 25
Lloydminster Hospital
Long-term Care Our Concern Group of Fort McMurray
Manufactured Housing Association Alberta and Saskatchewan
Medicine Hat Medications Awareness Committee
Medicine Hat Regional Hospital, Board of Directors
Medicine Hat Regional Mental Health Council
Mental Health Hospital Board, Alberta Hospital Edmonton
Mental Health Hospital Board, Alberta Hospital Ponoka
Minburn-Vermilion Health Unit
Misericordia Hospital
Mount View Health Unit Board and Staff
Muscular Dystrophy Association of Canada
National Council of Welfare
Native Council of Canada
Needs of the Elderly Planning Committee
Newell Community Action Group
Non-prescription Drug Manufacturers Association of Canada
Northern Alberta Children's Hospital Board
Northern Alberta Development Council
Northern Alberta Health Libraries Association
Northern Alberta Institute of Technology
Northwestern Health and Social Services, Board of Directors
Occupational Health Nurses, Central Alberta Chapter
Occupational Health Physicians of Edmonton
Olds General and Auxiliary Hospital and Nursing Home District No. 26
Ophthalmological Society of Alberta
Our Lady's Hospital, Vilna
Palliative Care Regional Council
Parent Resources Institute for Drug Education of Calgary
Peace River Health Unit No. 21
Pharmaceutical Manufacturers Association of Canada
Physician Payment Review Commission, United States
Planned Parenthood Alberta
Planned Parenthood Association of Edmonton
Premier's Council on the Status of Persons with Disabilities
Primary Health Care Interest Group
Professional Association of Internes and Residents of Alberta
Professional Care Services Ltd.
Professional Council of Registered Nursing Assistants
Provincial Committee of Community Health Nursing Administrators

APPENDIX IV

Provincial Mental Health Advisory Council
Provincial Senior Citizens Advisory Council
Psychologists Association of Alberta
Public Health Advisory and Appeal Board
Public Utilities Board
R.J.A. Medicentres Canada Inc.
Recreation, Parks and Wildlife Foundation
Red Deer Regional Health Unit Board
Red Deer Regional Hospital Centre
Red Deer Regional Mental Health Advisory Council
Regional Day Center Society of Edmonton, Adult Development Centre
Registered Nursing Assistants, Daysland Chapter
Registered Psychiatric Nurses' Association of Alberta
Residents of Salem Manor Nursing Home, Leduc, Alberta
Respiratory Suppliers' Association of Alberta
Royal Alexandra Hospitals
Royal Canadian Legion, Medicine Hat, Senior Citizen Housing Committee
Rural Health Care Association of Alberta
Salvation Army Calgary Grace Hospital Women's Health Centre
Senior Citizens' Central Council of Calgary
Sikh Federation of Edmonton
Sisters of Charity (Grey Nuns) of Alberta
Sleep Apnea Society of Canada, Calgary Chapter
Society for the Retired and Semi-Retired
Society of Alberta Medical Officers of Health
Society of Co-ordinated Home Care Program Administrators of Alberta
Society of Community Health Nursing Supervisors
Society of Remedial Masseurs and Physical Therapists
Sonshine Centre
South Peace Health Unit Board
Southeastern Alberta Community Resource Centre
Southeastern Alberta Health Unit
Southeastern Alberta Regional Psychiatric Planning Committee
Southern Alberta Institute of Technology
Southern Alberta Self-Help Association
Southern Rural Health Care Committee
Southland Nursing Home
Speech and Hearing Association of Alberta
St. Albert Association for the Handicapped
St. John Ambulance, Alberta Provincial Headquarters
St. Joseph's Hospital Staff
St. Mary's Health Care Centre, Trochu
St. Mary's Hospital, Camrose
St. Paul Regional Psychiatric Services, Planning Committee
Staff Nurses Association, Alberta East Central Health Unit No. 10
Staff Nurses Association of Alberta
Stony Plain-Lac Ste. Anne Health Unit
Sturgeon Health Unit
Suicide Prevention Provincial Advisory Committee
Summer Village of Whispering Hills
Taber and District Health Care Complex
Teen-Aid of Edmonton District Association
Therapeutic Touch Support Group
Turner Valley General and Auxiliary Hospital and Nursing Home District No. 66
Unisys Canada Health Care Services Centre
United Church of Canada, Alberta and Northwest Conference
University Hospitals Foundation
University of Alberta
University of Alberta Hospitals
University of Alberta, Centre for Gerontology
University of Alberta, Department of Anthropology, Project for the Study of Traditional Healing Practices
University of Alberta, Department of Education Foundations
University of Alberta, Department of Sociology, Population Research Laboratory
University of Alberta, Faculty of Dentistry
University of Alberta, Faculty of Education
University of Alberta, Faculty of Home Economics (Department of Foods and Nutrition)
University of Alberta, Faculty of Medicine
University of Alberta, Faculty of Medicine, Misericordia Family Clinic
University of Alberta, Faculty of Nursing
University of Alberta, Faculty of Pharmacy and Pharmaceutical Sciences
University of Alberta, Faculty of Physical Education and Recreation
University of Alberta, Faculty of Rehabilitation Medicine
University of Alberta, Health Law Institute
University of Alberta, Health Services Alumni Association
University of Alberta, Injury Awareness and Prevention Centre
University of Alberta, Western Centre for Economic Research
University of Calgary, Faculty of Medicine
University of Calgary, Faculty of Social Welfare
Vegreville Auxiliary Hospital & Nursing Home
Vegreville Health Unit
Victorian Order of Nurses for Alberta
Vulcan General Hospital and Nursing Home District No. 19
Weight Watchers of Alberta Ltd.
Weight Watchers of Saskatchewan Ltd.
Wetaskiwin Hospital District
Wetoka Health Unit Board
William Roper Hull Child and Family Services
Willow Creek-Claresholm Auxiliary Hospital and Nursing Home District No. 4
Women of Unifarm
Workers' Compensation Board of Alberta
Working Committee of the Coalition for Access to Abortion
YWCA Board of Directors, Edmonton
YWCA Social Issues Committee, Calgary

APPENDIX V
THE COMMISSION'S PROCESS

1.0 THE OVERALL PROCESS

On December 17, 1987, Premier Getty announced the establishment of the Premier's Commission on Future Health Care for Albertans. A copy of the Order in Council outlining the membership and Terms of Reference for the Commission's task is reproduced on page 3. In late December and early January, 1988, the Commission hired senior staff and established an office in Edmonton. At press time the total staff complement was 20. A listing of staff and consultants (past and present) is presented on page 13.

At its first meeting in Calgary, on January 20, 1988, Commission members discussed their visions for a preferred health future and established a plan for conducting its business to the end of December, 1989. Including the January 20, 1988 meeting, the Commission officially met over 45 times. In addition, Commissioners attended four planning sessions of 4 - 5 days duration.

All told, the Commission went through about nine phases from the initiation in January 1988 through to reporting to the Premier in December 1989. In reality, these phases blended into each other; however, briefly they were as follows:

Introduction (January - February 1988)

During this introductory period, the Commissioners reviewed the major health reports (eg. Hall Commission Report, Evans Report, Podborsky Report, Watson Report, Lalonde Report, Epp Report). They also notified the major health organizations in the province and invited them to present to the Commission in the Fall.

Interim Report on Nurses (February - June 1988)

After the nurses' strike, the Premier requested the Commission to study the underlying causes of the strike and make recommendations. During this phase, the Commission went through a cycle of listening, researching, integrating information, formulating recommendations and composing and publishing a report.

Creating a Vision (June - July 1988)

Returning to their original mandate, the Commissioners met at the end of June to develop a preliminary vision for the future health system.

Listening (June - November 1988)

The Commissioners started this phase by arranging townhall meetings throughout the province to listen to citizens - both consumers and providers of the health system. They also held public hearings where they listened to presentations made by sixty-eight major organizations in the health and health care systems.

In September, the Commissioners sent out the first newsletter which described their initial Mission and Principles for the health system and requested feedback.

Research (September 1988 - January 1989)

The Commission divided itself into three working committees: one to focus on promotion of health and prevention of disease and injury; one on acute care; and one on rehabilitation and long-term care. A research advisor was assigned to each committee to develop papers based on literature reviews of specific topics and issues. During this phase, the research focused mainly on what was, what is, and what would be if the current health and health care systems continued as they are today, and still try to meet the changes forecasted for the year 2000 and beyond.

In November, the second newsletter was mailed which outlined the process and progress of the Commission.

On December 12, 1988 the Commission co-sponsored a consultation on rehabilitation and long-term care with the Premier's Council on the Status of Persons with Disabilities. This consultation was attended by approximately 60 consumers and 60 providers.

In January, the Promotion and Prevention Committee sponsored a consultation on a Healthier Alberta. During this retreat, provincial, national, and international experts were invited to discuss ways in which Alberta could develop into a healthier province through enhanced programming in health promotion and the prevention of injury and disease.

Integration (January 1989 - March 1989)

During this time period, the Commissioners tried to integrate the literature research, and input from the citizens, consumers, providers, experts, and organizations that supplied us with information. The Commissioners identified the major issues and concerns and tested them against the vision they had developed. From this, they developed a number of "could be" scenarios and, finally, decided on a preferred or "should be" future. The principles were simplified and the essential components of this preferred future identified.

The third newsletter "What You've Said" which summarized the townhall meetings and presentations made to the Commission was distributed at the end of February.

Testing (March 1989 - June 1989)

The Commissioners developed an initial transformational plan; a plan describing how they could achieve this vision starting from today. They started testing their information and conclusions by meeting with a variety of groups and attending a number of meetings and conferences.

In April, the Commissioners also hosted an interprovincial conference. During this conference, they tested their vision and ideas with those who had gone through this process in their own provinces or on a national basis.

In May, the Commissioners co-sponsored with five other organizations a Strategic Forum on Mental Health. Of the approximately 100 participants, half were consumers and half were providers.

Re-Integration (July 1989 - September 1989)

Having tested their vision, principles, and essential components, and the major directions for change with a variety of groups, the Commission re-integrated this information and used it as the basis for their recommendations.

Composing the Reports (September 1989 - December 1989)

The Commissioners then refined their recommendations including target dates for implementation whenever appropriate. They were striving to make their recommendations practical, sensible, meaningful, evolutionary, and visionary as they developed both the video and written reports.

2.0 PROJECT RESEARCH

2.1 INVENTORY OF APPROACHES

INTRODUCTION

In preparation of this report, the Commission used several approaches to collect data and solicit views from the public on a preferred future for health in Alberta. All activities were complementary:

- literature search to determine the latest issues around the world;
- research studies to test views of the Commissioners on particular issues;
- public involvement through Town Hall meetings, submissions by telephone and in writing; and
- health care provider involvement through public hearings, written submissions and meetings by appointment.

DOCUMENTATION

Using the Terms of Reference provided by the Premier, the Commission undertook an extensive research program using primarily Alberta researchers. One of the first activities was a review of local, national and international literature in the health care field. In addition, various individuals were engaged in preparing working papers on various topics including:

Long-term Issues

1. Long-term Issues — Research Advisor: Lorne Dick

2. A Brief Review of the Responses to the Mirosh Report — Research Advisor: Lorne Dick

3. Housing Alternatives — Research Advisor: Lorne Dick

4. Single Entry: Its Importance to the Future of Long-term Care —
Research Advisor: Heather MacLean

5. Cost Benefit: Long-term Care Facilities, Home Care and Direct Payment Alternatives —
Research Advisor: Heather MacLean

Rehabilitation and Long-term Care

1. Consultation on Rehabilitation and Long-term Care, Finding Alternatives that Foster Health, Personal Control and Responsibility and Community Participation, December 12, 1988, Sheraton Cavalier Hotel, Calgary, Alberta; Prepared by: Nancy J. Marlett, in association with Heather MacLean, Dr. Fran Vargo, Dr. Martha Piper, Dr. Aldred Neufeldt, Bette Lou Smathers, Helen Cumming Norton, Dr. Roy I. Brown, E. Anne Hughson and the participants of the consultation.

Acute Care

1. Health Care System Organization Concepts for Consideration — Dr. Collins-Nakai, Mr. Bill Sturgeon
2. Paying the Health Care Bill — Research Advisor: Antoinette Alleyne
3. Paying the Hospitals — Research Advisor: Antoinette Alleyne
4. Paying for Physician Services — Research Advisor: Antoinette Alleyne
5. The Health Maintenance Concept Applied to Alberta —
   Research Advisor: Antoinette Alleyne
6. A Working Paper on Ambulance Services in Alberta —
   Research Advisor: Antoinette Alleyne

Health Promotion and Prevention

1. "PARTICIPACTION" - Background and Effectiveness —
   Senior Research Advisor: Habib Fatoo, Ph.D.
2. Smoking - Prevalence, Programs and Policies —
   Senior Research Advisor: Habib Fatoo, Ph.D.
3. Synopsis of Career and Life Management 20 — Research Advisor: Antoinette Alleyne

4. Public Policy in Relation to Preventative Health — Malcolm C. Brown, Ph.D., Professor of Economics, The University of Calgary, March 1989

5. Current Health Promotion Activities in Alberta — A working paper prepared by Chan Durrant Communications Ltd., December 15, 1988

6. Assessment of Innovative Health Promotion Programs — A working paper prepared by Chan Durrant Communications Ltd., December 15, 1988

7. Current Knowledge, Skills and Health Practices of Albertans — RPM Planning Associates Limited, January 1989

8. Health Status of Albertans — RPM Planning Associates Limited, January 1989

9. Dollars Following the Individual: Recommendations Affecting the Future of Health Care of Albertans — Research Advisor: Heather MacLean

10. The Premier's Commission on Future Health Care for Albertans: "Healthier Alberta: Developing a Health Promotion Agenda for Albertans." Final Report — George B. Cuff & Associates Ltd., Management Consultants, March 1989

Miscellaneous

1. Survey of Health Professionals A Pilot Study, September 26, 1989 — Ted Weiden and Associates Ltd.

2. Comparative Summary of Issues and Concerns Based on Summary of Public Hearing and Submissions, The Nova Scotia Royal Commission on Health Care and The Premier's Commission on Future Health Care for Albertans — Senior Research Advisor: Habib Fatoo, Ph.D.

3. Ethics and Patients' Rights — Research Advisor: Antoinette Alleyne

4. The Cost of Producing Health Care Personnel in Alberta — Research Advisor: Lorne Dick

5. Review of the Report of the Task Force on the Workers' Compensation Board, November 7, 1988, Chairman Vern Millard — Research Advisor: Antoinette Alleyne

6. An Overview of the Major Economic Trends in the Alberta Ecomony 1971 to 1987 — Richard H.M. Plain, Ph.D. (Economics)

7. Medical Service Expenditures and Utilization in Alberta (1970 - 1987) — Richard H.M. Plain, Ph.D. (Economics)

8. Medical Services Utilization and Expenditure in Alberta: The Projections 1988 - 2000 — Richard H.M. Plain, Ph.D. (Economics)

9. Mental Illness and Social Problems — C.A. Roberts, Ph.D. and Gus Thompson, Ph.D.

10. Mental Health in Alberta I: Philosophical Issues —
    A.H. Thompson, Ph.D. and C.A. Roberts, Ph.D.

    Mental Health in Alberta II: The Present Mental Health Care System
    A.H. Thompson, Ph.D. and C.A. Roberts, Ph.D.

    Mental Health in Alberta III: Mental Health Promotion and Innovative Strategies —
    A.H. Thompson, Ph.D. and C.A. Roberts, Ph.D.

11. A Nordic Perspective on Health Care — Suzanne Clark

12. Summary of Native Health Issues — Senior Research Advisor: Habib Fatoo, Ph.D.

13. Consistency of the Commission's Principles with the Principles Articulated in the Caring and Responsibility - Preliminary Paper — Senior Research Advisor: Habib Fatoo, Ph.D.

14. Future Directions for Health Care Services: Summary of Follow up Actions —
    Senior Research Advisor: Habib Fatoo, Ph.D.

15. The National Strategic Framework for Information Management in England —
    Senior Research Advisor: Habib Fatoo, Ph.D.

16. Alberta Health Report Card — Senior Research Advisor: Habib Fatoo, Ph.D.

17. Utility Rate Regulation: Its Applicability to Health Care —
    Senior Research Advisor: Habib Fatoo, Ph.D.

18. Alternative Therapies: A working paper developed for The Premier's Commission on Future Health Care for Albertans, July 1988 — Sharon J. Matthias

In addition to the research papers, documentation retained by the Commission includes all submissions and correspondence from Alberta and across Canada. Submissions were received by mail, delivered in person, delivered in public hearings, by toll free telephone line, site visits, and attendance by Commissioners and staff at many meetings and conferences.

All submission files and related administrative files will be available for viewing at the Public Archives after the Commission offices are closed on March 31, 1990.

APPENDIX V

PUBLIC HEARINGS

In February, 1988, the Commission asked for submissions from province-wide groups and organizations. Sixty-eight of those organizations presented briefs at the Public Hearings held in Edmonton in the fall of 1988.

It was important to both the Commission and province-wide groups to have an opportunity to discuss the future in an open and friendly atmosphere. Much of the Commissioners' time at the hearings was spent testing ideas, asking for clarification and seeking advice on the areas of prime importance for further consideration.

The Commission acknowledges the major time commitments and sincere efforts that went into the preparation of the written submissions and formal presentations. Newsletter Number Three entitled "What You've Said" published by the Commission in February, 1989, listed executive summaries or "conclusion pages" from each of the sixty-eight organizations that made presentations.

The following organizations presented briefs:

Alberta Alcohol and Drug Abuse Commission
Alberta Ambulance Operators Association
Alberta Association of Municipal Districts and Counties
Alberta Association of Naturopathic Practitioners
Alberta Association of Optometrists
Alberta Association of Registered Nurses
Alberta Association of Registered Occupational Therapists
Alberta Association of Social Workers
Alberta Cancer Board
Alberta Community Health Nurses Society
Alberta Council on Aging
Alberta Dental Association
Alberta Foundation for Nursing Research
Alberta Friends of Schizophrenics
Alberta Heritage Foundation for Medical Research
Alberta Hospitals Association
Alberta Long Term Care Association
Alberta Medical Association
Alberta Nursing Education Administrators
Alberta Pharmaceutical Association
Alberta Registered Dietitians Association
Alberta Roman Catholic Bishops' Conference
Alberta Senior Citizens Homes Association
Alberta Society of Orthopaedic Surgeons
Alberta Status of Women Action Committee
  (Edmonton Working Women)
Alberta Union of Provincial Employees
Blue Cross
Calgary Board of Health
Canadian College of Health Service Executives
Canadian Drug Manufacturers Association
Canadian Mental Health Association
Canadian Organization of Small Business
Canadian Red Cross Society, Alberta Division
Canadian Union of Public Employees, Alberta Division
Centre for Gerontology
College of Chiropractors of Alberta
College of Family Physicians of Canada, Alberta Chapter
College of Physical Therapists of Alberta
  (Alberta Physiotherapy Association;
  Independent Physical Therapists of Alberta)
College of Physicians and Surgeons
Consumers Association of Canada, Alberta Division
Council of Teaching Hospitals of Alberta
Denturist Society of Alberta
Easter Seal Ability Council
Edmonton Board of Health
Edmonton Social Planning Council
Friends of Medicare
Glenrose Rehabilitation Hospital
Health Sciences Association of Alberta
Health Unit Association of Alberta
Heart Health Task Committee
Pharmaceutical Manufacturers Association of Canada
Professional Association of Internes and Residents of Alberta
Professional Council of Registered Nursing Assistants
Provincial Senior Citizens' Advisory Council
Psychologists Association of Alberta
Registered Psychiatric Nurses Association of Alberta
Rural Health Care Association of Alberta
Sisters of Charity (Grey Nuns) of Alberta
Society for the Retired and Semi-Retired
Society of Alberta Medical Officers of Health
Staff Nurses Association of Alberta
Suicide Prevention Provincial Advisory Committee
University of Alberta
University of Calgary, Faculty of Medicine
University of Calgary, Faculty of Social Welfare
Victorian Order of Nurses
Women of Unifarm
Workers' Compensation Board of Alberta

APPENDIX V

Some of the features of the Public Hearings were as follows:

1. All were open to the public and the media.
2. All sessions were recorded on video tape, and copies were made available to all participating groups.
3. Submissions were obtained from the groups ahead of time and executive summaries were presented to each Commissioner prior to the hearing. Each spokesman for the group was asked to present a short introduction on the major points in their brief. A question and answer period followed. Each session lasted approximately one hour and thirty minutes. It should be noted that some groups added new information at the hearings.

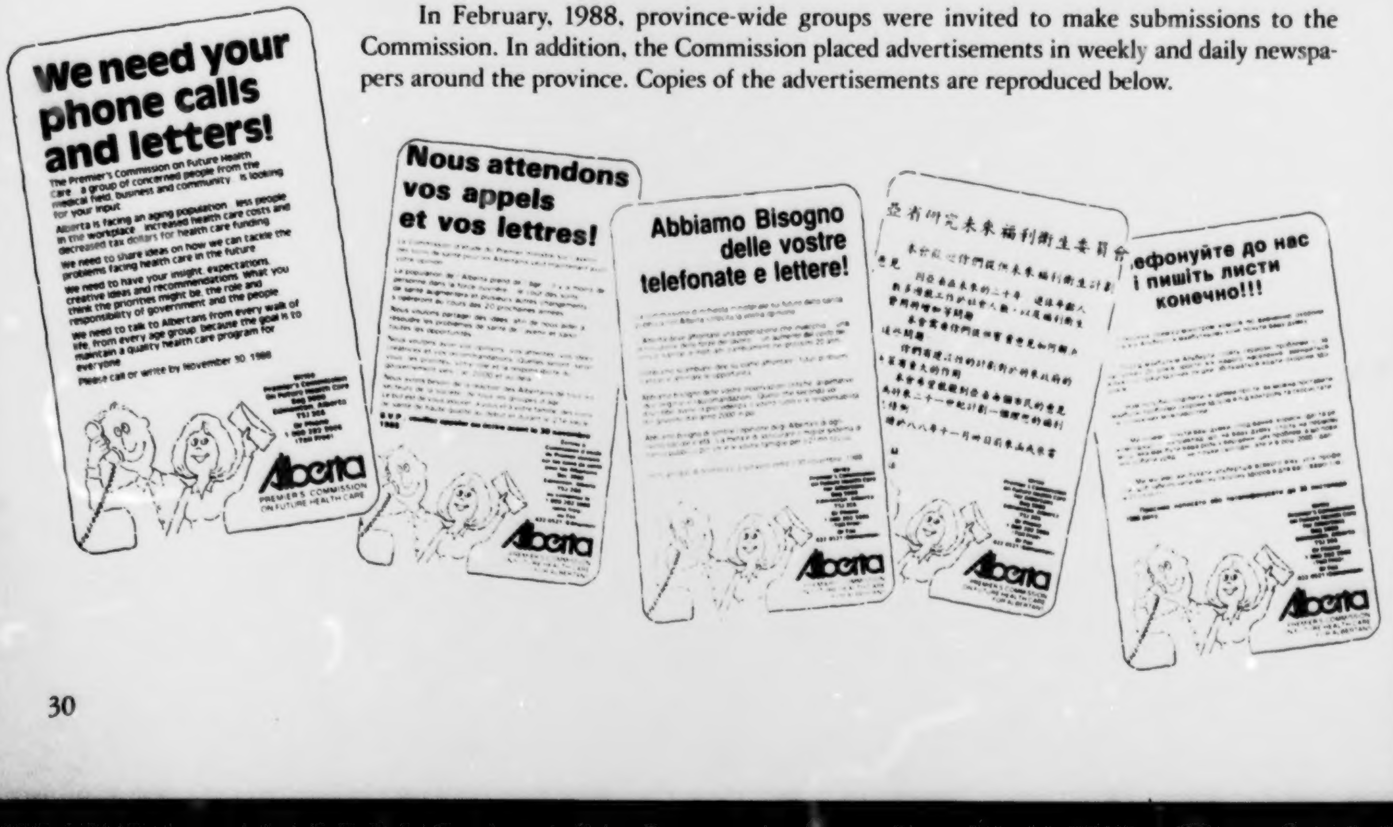
The public hearings were held at the Edmonton Inn on September 15 and 16, 1988 and in the Alberta Tourism Boardroom, 10025 Jasper Avenue, Edmonton, Alberta, T5J 3Z3 on the following dates:

October 17 - 19, 1988	November 16-18, 1988
October 21, 1988	November 22 - 25, 1988

All major issues, problems, and solutions raised during the hearings were summarized and added to our submissions data base. This data base allowed our research staff to assess and summarize the major issues raised during the public Town Hall Meetings and the hearings. A summary of the recommendations and comments was valuable input to the Final Report.

PUBLIC SUBMISSIONS

In February, 1988, province-wide groups were invited to make submissions to the Commission. In addition, the Commission placed advertisements in weekly and daily newspapers around the province. Copies of the advertisements are reproduced below.



We need your phone calls and letters!

The Premier's Commission on Future Health Care — a group of concerned people from the medical field, business and community — is looking for your input.

Alberta is facing an aging population — less people in the workplace — increased health care costs and decreased tax dollars for health care funding.

We need to share ideas on how we can tackle the problems facing health care in the future.

We need to have your insight, expectations, creative ideas and recommendations. What you think the priorities might be, the role and responsibility of government and the people.

We need to talk to Albertans from every walk of life, from every age group because the goal is to maintain a quality health care program for everyone.

Please call or write by November 30, 1988

Write
Premier's Commission
on Future Health Care
[illegible]
Edmonton, Alberta
[illegible]
Or Phone
[illegible]
(Toll Free)

Alberta
PREMIER'S COMMISSION
ON FUTURE HEALTH CARE

Nous attendons vos appels et vos lettres!

Abbiamo Bisogno delle vostre telefonate e lettere!

亞省研究未來福利衛生委員會

ефонуйте до нас і пишіть листи конечно!!!

In total, the following number of submissions were received: 531 toll free telephone calls, 560 letters from individuals, 513 briefs from groups and organizations of which 68 were presented at public hearings.

All submissions received were acknowledged and filed in a computerized index system to allow the Commission to retrieve files easily. Each of the major issues, problems and solutions raised by those contacting the Commission was included in our submissions data base as noted on page 35.

One of the major unheralded aspects of the Commission's work was the bringing together of groups that were not previously discussing matters of mutual interest. Commission members have all acted as catalysts to encourage dialogue among and between stakeholder/interest groups.

PUBLIC TOWN HALL MEETINGS and SITE VISITS

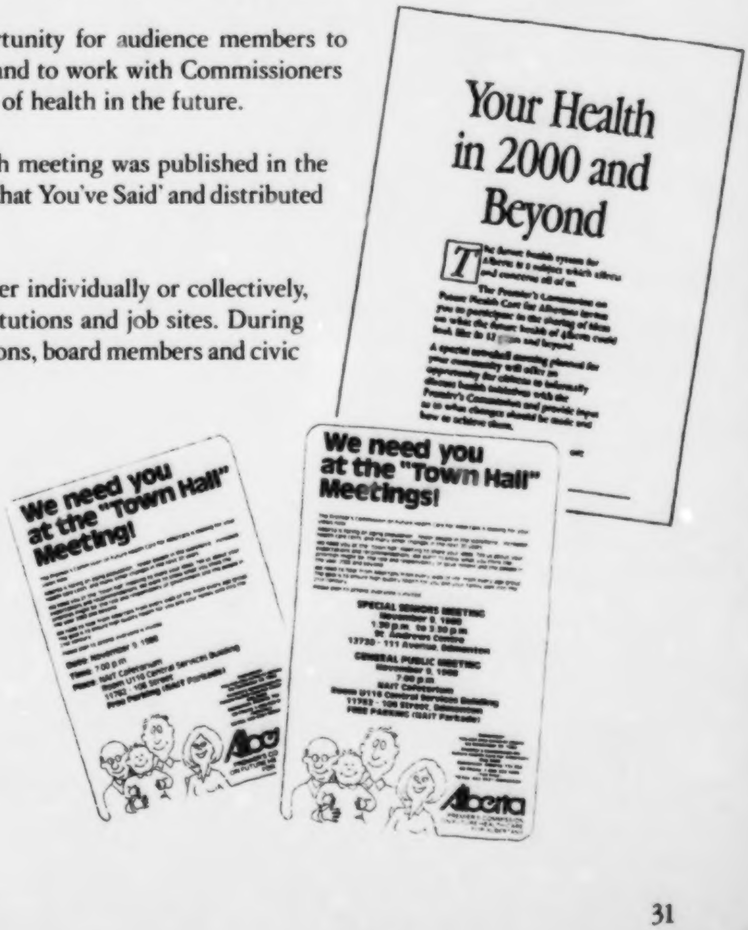
The Commission encouraged public involvement by conducting 14 public Town Hall meetings in different locations throughout the province (including urban and rural centres) from June to November 1988.

Almost 1,000 citizens participated in the Town Hall meetings devoted to discussing the preferred characteristics of the future health system to serve all Albertans.

The consultation process provided the opportunity for audience members to express individual concerns, insights and opinions and to work with Commissioners in small groups to brainstorm on numerous aspects of health in the future.

The detailed list of all the topics raised at each meeting was published in the February 1989 special edition newsletter entitled, 'What You've Said' and distributed to more than 14,000 Albertans.

Since January, 1988, the Commissioners, either individually or collectively, visited many health care facilities, educational institutions and job sites. During their travels they also met with numerous organizations, board members and civic officials.



Your Health in 2000 and Beyond

We need you at the "Town Hall" Meeting!

We need you at the "Town Hall" Meetings!

APPENDIX V

A list of the site visits in association with Town Hall meetings follows:

LOCATION OF PUBLIC TOWN HALL MEETINGS

1) Pincher Creek
2) Lethbridge
3) Medicine Hat
4) Red Deer
5) Drumheller
6) Vermilion
7) Bonnyville
8) Athabasca
9) Fort McMurray
10) Grande Prairie
11) Peace River
12) High Level
13) Edmonton (2)
14) Calgary (2)

OTHER LOCATIONS VISITED

A) Oldman River Damsite
B) Lethbridge - 2 hospitals, health unit, nursing home (Extendicare)
C) Taber - Health Centre
D) Bow Island
E) Medicine Hat - hospital, City Social Services
F) Oil Rig Site - Eckville
G) Galahad - Hospital
H) St. Paul - Mayor and Councillors
I) Athabasca - Hospital and Athabasca University
J) Mildred Lake - Syncrude Site
K) Ft. McMurray - Hospital
L) Grande Prairie - Health Unit, Crystal Park School, High School Class
M) Fairview - Agricultural College
N) Manning - High School Class
O) High Level - FCSS office, Health Centre

- Oldman River Damsite; Canadian Mental Health Association Representatives; Family and Community Support Services Representatives; Pincher Creek Hospital Board; Town Hall Meeting: Heritage Inn, Pincher Creek, June 13, 1988

- Lethbridge Regional Hospital; St. Michael's Hospital; Lethbridge Home Care and Palliative Care Office; Lethbridge Extendicare Nursing Home; Southern Alberta Health Care Committee; Town Hall Meeting: Sandman Inn, Lethbridge, June 14, 1988

- Taber and District Health Care Complex, June 15, 1988

- Bow Island Health Centre, June 15, 1988

- Dominion Glass Factory, Redcliff; Medicine Hat Regional Hospital; Mayor and Family and Community Support Services; Town Hall Meeting: Medicine Hat Lodge, June 16, 1988

- Town Hall Meeting: Great West Inn, Red Deer, June 20, 1988 Dr. Victor Kumar-Misir regarding Multicultural Health Issues, June 21, 1988

- Arrowhead Drilling Oil Rig Site (3 miles North of Eckville, Alberta), June 21, 1988

- Town Hall Meeting: Drumheller Inn, Drumheller, June 21, 1988

- Galahad Hospital Board, Galahad, June 22, 1988

- Town Hall Meeting: Elks Hall, Vermilion, June 22, 1988

- John Drobot, M.L.A., St. Paul; Mayor Paul Langevin and Councillors, St. Paul, September 12, 1988

- Town Hall Meeting: Agriplex, Bonnyville, September 12, 1988

- Athabasca General and Auxiliary Hospital Board; Athabasca University; Town Hall Meeting: Athabasca Inn, Athabasca, September 13, 1988

- Mildred Lake: Syncrude Canada Ltd. Site, September 14, 1988

- Fort McMurray Regional Hospital Town Hall Meeting: Sawridge Hotel, Fort McMurray, September 14, 1988

- South Peace Health Unit, Grande Prairie; Crystal Park School, Grande Prairie; Grande Prairie Grade Eleven High School Class, Grande Prairie; Family and Community Support Services, Grande Prairie and Area Directors; Town Hall Meeting: Grande Prairie Inn, Grande Prairie, October 11, 1988

- Fairview Agricutural College, Fairview, October 12, 1988

- Manning High School Grade Eleven Class, Manning; Mayor and Manning Hospital Board, Manning, October 12, 1988

- Town Hall Meeting: Athabasca Hall, Peace River, October 12, 1988

- Family and Community Support Services Office, High Level; North Western Health Centre and Social Services Board, High Level; Town Hall Meeting: Florence McDougall School, High Level, October 13, 1988

- Various meetings by appointment, Edmonton

- Various meetings by appointment, Calgary

CONFERENCES HOSTED

Long-term Care and Rehabilitation

In addition to Commissioners attending conferences, the Commission officially co-sponsored several major conferences. The first was the Consultation on Long-term Care and Rehabilitation held in Calgary on December 12, 1988.

The Consultation was held at the end of the first year of the project to allow interested groups to discuss the many briefs, submissions and reports on rehabilitation and long-term care. Input and reactions were received from consumers and innovative service providers who had not had the opportunity to submit material to the Commission. The consultation was co-sponsored by the Premier's Council on the Status of Persons with Disabilities.

Prevention and Promotion

On January 22 - 24, 1989, an internationally distinguished group of disease prevention and health promotion experts attended a consultation held in Calgary entitled "Healthier Albertans". The purpose of the workshop was to examine carefully, comprehensively and coherently the state of the science and practice of enhancing health and to suggest concrete strategies and priorities for the rest of the twentieth century and into the next century. Specifically, the objectives of the workshop were:

— to learn about the relationships between various factors and health status;
— to identify and analyze trends in these factors which have a known impact on health status; and
— to develop strategies and action plans on how best to protect and enhance the health of Albertans.

This workshop was a useful part of the data gathering segment of the Commission's mandate. It enabled the Commission to gather together a group of renowned experts from various segments of the health promotion and disease prevention fields to share their observations with the members and their colleagues to develop a health promotion agenda for Alberta.

Mental Health

Commission staff assisted in the planning of a consultation on Mental Health Services held in Red Deer on May 29, 1989.

The idea for this consultation arose as a result of the mental health submissions made to the Premier's Commission. The mental health submissions represented a wide range of views with depth and insight. Many groups made presentations on mental health issues which generated even more interest in the concept of mental health and in seeking ways to improve mental health and mental health care for Albertans.

This forum provided the opportunity to examine the mental health issues presented to the Premier's Commission, to help participants realize their assumptions about mental health/ mental illness today and to explore how it could look in the future, and to stimulate participants (providers/consumers) to think about how they can personally influence change.

Interprovincial Conference

On April 26 - 28, 1989 representatives of past and present health commissions, councils and committees met in Edmonton to learn from each other as to what contributed or was contributing to the success of the work of each Commission or group. Participants were asked to discuss how Commissions/Government Departments help or hinder each other's work. Alberta's Commission requested feedback from attendees on their work to date and advice on completing their report.

The Commission gratefully acknowledges the time and effort provided by participants and the financial contribution by Health and Welfare Canada.

MEETINGS (Formal and Informal)

In order to fully understand the workings of the health and health care system in Alberta, Commissioners and staff attended more than 200 meetings mainly in Alberta. Consultation with others in an effort to broaden the scope of their knowledge was conducted primarily by electronic means via the Commission's computer system. Several smaller trips were made to northeastern United States and southwestern United States for specific consultations.

Commissioners also attended close to 100 conferences and seminars, which supplemented their growing knowledge of health care. The meeting and conference list will be available in Commission files at the Provincial Archives after March 31, 1990.

SPECIAL WORKSHOPS

In addition to the foregoing activities, the Commission sought further input from two special groups - senior citizens and young adults.

Although the Commissioners had spoken to many senior citizens at various public meetings, they conducted two November 1988 workshops just for seniors - one in Edmonton and one in Calgary. The frank dialogue touched on a number of issues unique and pertinent to elderly people in an endeavour to address the future health care needs of the aging population and to improve the quality of life of older people. All the concerns and suggestions of the workshop participants were published in "What You've Said", the Commission's special edition newsletter issued in February 1989.

The Commission also recognized that today's youth should play an important role in considering and planning the future health system. During the Commission's fall 1988 travels to northern Alberta, the Commissioners talked with two classroom groups — the Grade 11 class at Paul Rowe High School in Manning and the Grade 11 class at Grande Prairie High School in Grande Prairie.

Later in November 1988, with Dr. Louis Francescutti as moderator, the Commission sponsored formal youth workshops in Edmonton and Calgary meeting students who represented a wide variety of schools in those cities and surrounding areas. The students exchanged views on numerous health topics of special concern to young people such as accident/injury prevention and shared thoughts and opinions on several thorny issues facing health policy decision-makers such as abortion, euthanasia, suicide, etc. A synopsis of the youth workshops appears in the "What You've Said" newsletter.

2.2 SUBMISSIONS DATA BASE

To assist the Commission in analyzing submissions made or presented in response to invitations, public advertisements and town hall meetings, a computerized data base was established. This data base was also used to obtain the quotes for the Report. Some of the comments or quotes may have been edited because of space requirements.

To allow us to summarize what Albertans were telling us, we organized our data base as shown in Figure 1. All submissions were individually reviewed and all the issues were recorded. Each issue was further divided into a defined problem and the suggested solution(s). These issues were then categorized into major issues and more general topics. Figure 1 below shows the structure of the data in the data base.

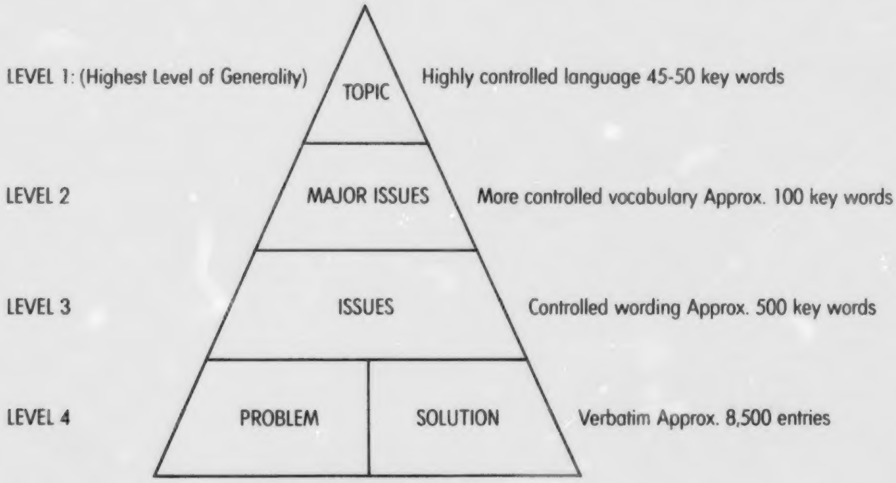

LEVEL 1: (Highest Level of Generality)
TOPIC
Highly controlled language 45-50 key words
LEVEL 2
MAJOR ISSUES
More controlled vocabulary Approx. 100 key words
LEVEL 3
ISSUES
Controlled wording Approx. 500 key words
LEVEL 4
PROBLEM
SOLUTION
Verbatim Approx. 8,500 entries

FIGURE 1: STRUCTURE OF DATA

Data was retrieved by using the key words at each level. For example, every word a person used to describe a problem and its solution was included in the key word list at the "problem/solution" level. By reading data at this level, the Commissioners could determine the context in which an issue was raised. For example, the word "fund" sometimes meant an individual's personal resources, sometimes the budget of an organization, and sometimes the state of the economy.

These different meanings of the word "fund" were analyzed as well. For example, if the word "fund" meant "personal resources", it would be classified under the topic "resources". If the person was addressing the "state of the economy", it would be classified under the topic "fiscal". It would be classified under the topic "funding" if they were addressing "organization budgets".

APPENDIX V

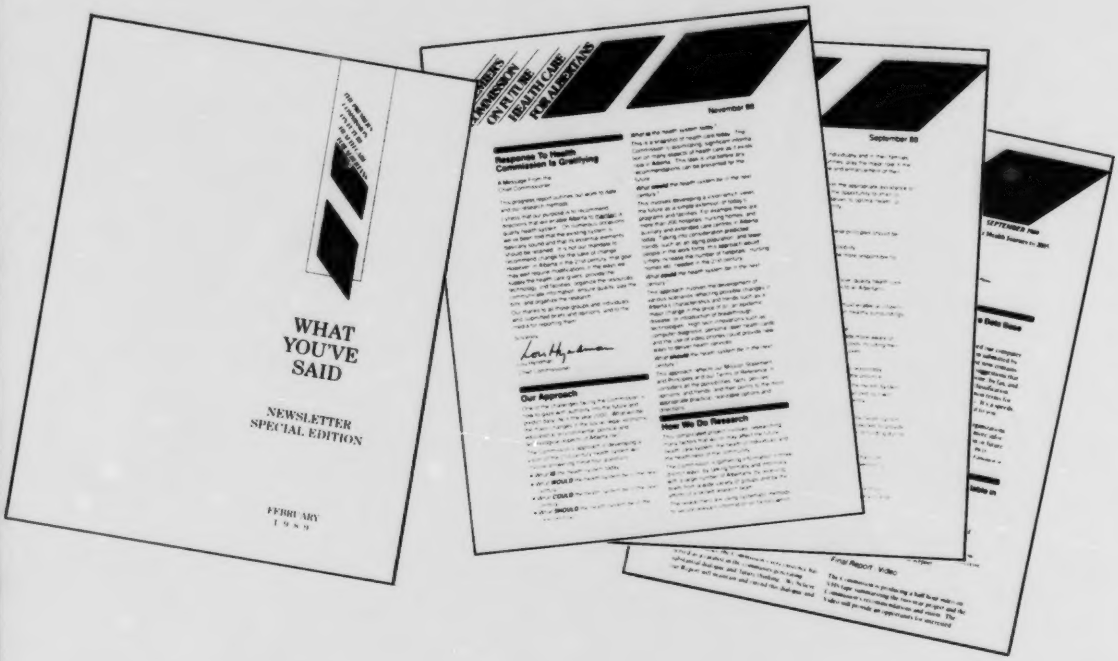
The most effective and efficient level to retrieve data appeared to be at the "issue" and "major issue" levels. Examples of key words for the "major issues" and "issues" shown in Figure 1 are presented below:

Level 1 Health System Topics	**Level 2/3 Terms for Issues**
Administration	Delegation, Centralization, Decentralization of Authority/Responsibililty, Cooperation, Consultation, Integration, Liaison, Quality in performance of functions, Involvement, Participation, Support, Recognition, Status of Stakeholder, Review/Assessment of management
Facilities	Access, Accreditation, Alternatives, Costs/Benefits, Allocation/Distribution, Design, Number, Capacity, Service Capability, Unit/Ward Specialization, Utilization
Services	Access, Supply, Availability/Delivery, Level, Eligibility, Utilization, Alternatives/Options, Costs/Benefits, Continuity, Integration, Coordination, Efficiency/Productivity Timeliness, Quality/Standards, Patterns/Trends
Professional	Specialization, Practice Boundaries/Jurisdiction, Recognition/Involvement, Knowledge/Qualifications, Skill/Competence, Conduct, Ethics, Licensure/Certification, Review/Discipline
Insurance	Access, Costs of Plans/Premiums, Coverage of Services within Fee Schedule, Mechanism of Paying Health Providers
Funding	Access/Availability Level, Allocation/Distribution, Incentives, Mechanisms/Sources, Alternatives/Options
Equipment	Access, Costs/Benefits, Safety, Supply, Allocation/Distribution, Utilization
Manpower	Costs, Allocation/Distribution, Quality, Number, Utilization, Alternatives, Supply/Recruitment, Compensation, Working Conditions
Information	Access, Costs/Benefits, Supply/Availability/Delivery, Confidentiality, Communication/Dissemination
Training	Access, Supply/Availability, Costs/Benefits, Curriculum, Standards, Eligibility/Admission Criteria, Recruitment/Enrollment, Tuition/Financing
Research	Costs/Benefits, Review/Assessment, Quantity

For more information on definitions, the process, and to learn how one can use the data base for individual projects or needs, please call our office at 422-1106 until March 31, 1990. After April 1,1990, access to the data base will be through the Alberta Health Library at 427-3530.

3.0 COMMISSION NEWSLETTERS

During the two years of operation, the Commission produced newsletters, including a special edition entitled "What You've Said" that was widely distributed.



WHAT
YOU'VE
SAID

NEWSLETTER
SPECIAL EDITION

FEBRUARY
1989

Response To Health Commission Is Gratifying

Our Approach

How We Do Research

4.0 PROJECT BUDGET

During the early planning stages of the Commission, budgets were prepared for the three month period ending March 31, 1988, fiscal year 1988/89 and fiscal year 1989/90. Budget and expended amounts are as follows:

	BUDGET	EXPENDED
	$	$
1987/88	295,000	235,000
1988/89	1,950,000	1,875,000
1989/90	1,905,000	not available

All work of the Commission to date has been under budget. It is anticipated that the budget expenditures for the fiscal year 1989/90 will as well be under budget.

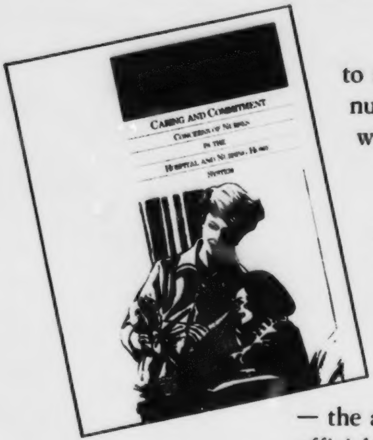
To put the Commission's total budegetary allocations of $4.2 million into perspective, this total is equivalent to the cost of running Alberta's health system for less than half a day.

APPENDIX VI

INTERIM REPORT: CARING AND COMMITMENT — CONCERNS OF NURSES IN THE HOSPITAL AND NURSING HOME SYSTEM

Government Response: News Release, December 22, 1988

$7.5 Million to Address Nursing Concerns



Premier Don Getty, and Nancy J. Betkowski, Minister of Health announced initiatives to address concerns in the delivery of health care, with a particular emphasis on the nursing profession. $7.5 million will be committed in the first year of a four-year program with similar funding as required over the following three years.

These initiatives follow recommendations made by the Premier's Commission on Future Health Care for Albertans. The Commission's Interim Report: Caring and Commitment: Concerns of Nurses in The Hospital and Nursing Home System, was released in June of this year.

Key initiatives of the program are:

— the appointment of a senior nursing consultant to work with the Department of Health officials in addressing current and future concerns associated with the nursing professions.

— the appointment of a nurse to the following hospitals boards: the Alberta Children's Hospital, the Glenrose Hospital, the Foothills Hospital, the University of Alberta Hospitals, the Alberta Cancer Board, the Charles Camsell, the Alberta Hospital - Edmonton, and the Alberta Hospital - Ponoka. The individual chosen by the nurses in each of these hospitals will be appointed by Executive Council to the respective hospital boards at the earliest opportunity. The boards of these hospitals are appointed entirely by Executive Council.

As well, the government will undertake to consult with nurses and the remaining hospital boards throughout Alberta to determine the most appropriate means of ensuring nurses are a meaningful part of the decision making process.

— information about and funding for universal safety precautions.
— the establishment of a nurses advisory committee to review nursing issues, such as staffing, job enhancement and post-basic critical care training.

"These initiatives recognize the important role which nurses have in our health system," said the Premier, "and will ensure that nursing personnel have input to those decisions which affect their profession."

The Department of Advanced Education will make changes to help nurses in upgrading their skills. These will include:

— expanding opportunities in post-basic specialization for nurses in critical care and long-term care.

— increasing support for projects aimed at developing a continuum between diploma and degree-level training.

— increase access to the post-diploma baccaulareate program.

"Increasing educational opportunities is a priority for our government," said the Premier, "and providing specific initiatives for nurses is in keeping with our overall educational strategy."

Initiatives in Service Delivery (Backgrounder to release)

The Department of Health will assume responsibility for the following initiatives:

1) Universal Infection Control

Sponsoring information workshops on necessary infection control precautions.

Provide additional funding for supplies and equipment to deal with infection control.

2) Appointment of a Senior Nursing Consultant

The consultant would be responsible for: coordinating government initiatives concerning institutionally-based nursing personnel; establishing contact with key nursing stakeholder groups and monitoring nursing developments in services and educational levels.

3) Appointment of Nurses to Hospital Boards

A nurse will be appointed to the boards of each of the hospitals whose boards are appointed by Cabinet, these include: The Alberta Children's Hospital, the Glenrose Hospital, the Foothill's Hospital, the University of Alberta Hospitals, the Cross Cancer Institute, the Charles Camsell, the Alberta Hospital Edmonton and the Alberta Hospital Ponoka.

In addition, consultation will take place with regard to possible representation of nurses on other hospital boards.

4) Job Enhancement Advisory Committee

Functions of the Committee to include:

advising the Minister with regard to the Job Enhancement Fund;
will assist in the review of staffing guidelines; and
any other issues with respect to nursing in hospitals and nursing homes which the Minister may refer.

5) Job Enhancement Fund

The establishment of a dedicated fund of $4.5 million in hospital budgets for job enhancement initiatives. The advisory committee will assist in the development of guidelines for the type of eligible activities.

Establish an additional $2 million fund on a cost-shared basis. The advisory committee will assist in the development of an application process, criteria for selected projects and the recommendation for projects to be approved.

Initiatives in Nursing Education (Backgrounder to release)

The Department of Advanced Education will provide funding to post-secondary institutions to support three specific areas of nursing education.

1) Expand Opportunities for Post-Basic Specialty Training

Acute care nursing: additional training capacity will be added to address a province-wide shortage of critical care nurses. In conjunction with the Department of Health, the post-basic certificate program in critical care nursing will be expanded in Edmonton and a new program established in Calgary.

Gerontology: new training spaces will be added to the college system to provide post-basic training for nurses in long-term care/gerontology nursing. This initiative will emphasize a flexible distance delivery learning format which will make it accessible to nurses employee outside the major urban centres.

2) Enhance Access to Post-Diploma Baccalaureate Programs

The post-diploma baccalaureate programs offered at the Universities of Alberta, Calgary and Lethbridge, will be expanded and offered by distance delivery so that diploma R.N.'s in rural communities will have an opportunity to complete baccalaureate level training in nursing. Support will also be provided to Athabasca University's cooperative transfer program, which allows nurses to take part of their university courses by home study, reducing the on-campus study requirements of the baccalaureate program.

3) Support Curriculum Integration between Diploma and Degree-Level Training

Support will be provided to integrate nursing education programs so that diploma nursing students will have more opportunity to receive credit for their training if they transfer into university-level programs. Transfer links will be developed between the programs offered in colleges and hospital-based schools of nursing, and the baccalaureate programs at the University of Alberta and the University of Calgary.

The Department will work closely with nursing educators in the various institutions and officials in the Department of Health, to effect implementation of these initiatives in 1989.

SUMMARY OF GOVERNMENT'S RESPONSE BY COMMISSION RECOMMENDATION

The initiatives announced by Government are presented below according to the Terms of Reference given to the Commission by Premier Getty in February 1988.

Initiatives Directed at Terms of Reference A.

"To ascertain facts and make recommendations in respect of the major concerns of nurses regarding their opportunity to advance academically and through increased experience in subspecialized areas of nursing care and to have this increased expertise recognized by hospital boards."

Recommendation A.1: Department of Advanced Education provide increased funding to the Universities of Alberta, Calgary, and Lethbridge to enable them to increase enrollment quotas in basic and post-basic programs.

Responses to Recommendation A.1: Post-diploma baccalaureate programs have been expanded at the University of Calgary (50 spaces per year) and the University of Lethbridge (25 spaces per year). A new distance delivery program will be offered by Athabasca University (25 spaces per year) starting in 1990, to be expanded to 50 spaces by 1994. These initiatives will now enable more R.N.s to complete B.Sc./B.N. studies on a part-time or full-time basis.

Recommendation A.2: That within 2 years the Faculties of Nursing initiate and evaluate a nurse internship pilot project whereby new graduates are paid a salary while enhancing their clinical skills. This should include a mixture of rural and urban experience.

Recommendation A.3: That the Alberta Association of Registered Nurses actively support the implementation of the Canadian Nurses Association's certification program for the various clinical specialties in nursing.

Responses to Recommendation A.3: The Deparment of Advanced Education is funding selected post-secondary institutions to offer programs in: 1) post-basic critical care nursing. The post-basic certificate program in critical care nursing at the Misericordia Hospital was expanded from 30 - 60 spaces and a new program with 64 spaces was approved for the Foothills Hospital. 2) post-basic gerontology/long-term care nursing. Alberta Health is assisting Alberta Advanced Education and the responsible institutions to define the skills and competencies that should be included in a new post-basic gerontology/long-term care nursing curriculum. These programs are to emphasize flexible local delivery to make the program more accessible to nurses employed outside the major urban centres.

Recommendation A.4: That the Department of Advanced Education through such bodies as the Alberta Council on Admissions and Transfer, collaborate with the appropriate educational institutions and professional associations to establish a mechanism for consistent crediting of appropriate courses and experience for transfer from one type of nursing program to the next.

Responses to Recommendation A.4: Funds have been provided to collaborative planning committees in Calgary and Edmonton to develop and assess the feasibility of specific curriculum models that would improve integration of nursing education programs offered in colleges, hospital-based schools and universities.

Recommendation A.5: That funding of continuing nursing education programs be increased by the year 1990. Responsibility for funding continuing education programs must rest jointly with the individual nurses, employers, post-secondary educational institutions, professional bodies, collective bargaining associations, and the appropriate departments of government, with the Minister of Advanced Education taking the lead role.

Responses to Recommendation A.5: A total of $4.5 million will be earmarked in global budgets of acute care hospitals for continuing education and job enhancement activities (this is in addition to the Premier's $7.5 million package).

To replace nurses taking continuing education, Alberta Health has made available funding of $2.5 million for the fiscal year 1989/90 to fund an additional eight hours for each full-time equivalent Registered Nurse, Graduate Nurse, Registered Psychiatric Nurse, Registered Nursing Assistant position, and to fund replacement relief costs for the identified staff to undertake education in other professional development activities.

Recommendation A.6: That the Alberta Association of Registered Nurses institute a policy of mandatory continuing education for nurses to update their knowledge and skills in order to retain their active registration status.

Recommendation A.7: That individual nurses who are evaluated by their supervisors as having provided superior performance or demonstrated outstanding expertise be rewarded accordingly.

Responses to Recommendation A.7: On May 16, 1989, the Minister of Health announced the membership of the Job Enhancement Advisory Committee, chaired by Mrs. Marlene Meyers. The Committee has a mandate to advise the Minister on initiatives in Alberta hospitals and nursing homes to promote the retention and job satisfaction of nursing personnel. The Job Enhancement Advisory Committee will develop application and selection guidelines for proposals and will recommend projects to be approved for a $2.0 million fund that has been established for this purpose on a cost-shared basis.

On August 17, 1989, Mrs. Meyers sent a letter asking all facilities planning to submit a proposal for the 1989/90 fiscal year to submit a letter of intent by September 15, 1989.

As of December 8, 1989, five proposals totalling $242,530 were approved and another eight proposals totalling $877,155 were approved in principle.

Initiatives Directed at Terms of Reference B.

Recommendation B.1: That all hospitals and nursing homes be required to review working environments to ensure that they are safe and secure, and that procedures are in place to deal with hazardous or crisis situations, and that the procedures and appropriate training be provided to staff.

Responses to Recommendation B.1: Alberta Health is developing a two-phased program to assist long-term care facilities in the development and implementation of infection prevention programs which will promote the safety and well-being of all residents and staff.

Phase I will assist institutions with the implementation of universal infection control precautions such as unidentified carriers of blood-born infections such as hepatitis B, and HIV.

In Phase II, the broader aspects of preventing and controlling all types of infection in long-term care institutions will be addressed.

Initiatives Directed at Terms of Reference C.

Recommendation C.1: That the Department of Hospitals and Medical Care (now Alberta Health) evaluate the current nursing staff guidelines used by the Department. Once established, those guidelines should be provided to hospitals and nursing homes for their information.

Responses to Recommendation C.1: Alberta Health appointed a provincial nursing consultant reporting directly to the Deputy Minister of Health, effective February 1, 1990. In Long-Term Care, a case mix funding system is being introduced which specifies the ratio of R.N.'s, R.N.A.'s and other nursing personnel.

Recommendation C.2: That hospital management use patient classification systems and admission monitoring systems as guidelines only, and in conjunction with personal judgement, to assign staff and patients.

Responses to Recommendation C.2: Nursing staffing guidelines have been discussed by the Steering Committee of the Acute Care Funding Project. The objectives of this project are to design and implement changes to the acute care hospital funding process in consultation with health care partners. This project was initiated in the Fall of 1988, and is examining the issues of: 1) severity of patient illness indices, 2) the need to separate out-patient from in-patient funding, and 3) the perception that the present system is not fair or equitable. Through this project, Alberta Health wants to ensure that the processes chosen to determine levels of funding accurately reflect required nursing resources.

In the Long-Term Care system a case mix funding system was implemented in 1988/89. This system is intended to ensure that funds for nursing care are equitably distributed among Long-Term Care institutions.

Recommendation C.3: That hospital and nursing home managers and collective bargaining associations introduce ways to increase the flexibility of work schedules.

Recommendation C.4: That the Alberta Hospital Association create regional councils comprised of representatives from hospital boards and professional associations to clarify "grey areas" of authority, accountability, and responsibility among nurses, physicians, and other health care providers.

Recommendation C.5: That the government encourage pilot projects involving private nursing companies which would contract their services to an entire hospital or a nursing home, or particular units within a hospital or nursing home.

Recommendation C.6: That representatives of health care providers appoint, with government, on a five-year trial basis a health Ombudsman/Advocate to document and investigate complaints from nurses and other health care providers.

Responses to Recommendation C.6: The Minister has appointed a Job Enhancement Advisory Committee which has the mandate to advise her on initiatives in Alberta hospitals and nursing homes to promote the retention and job satisfaction of nursing personnel, and to consult on any other nursing-related issues referred by the Minister for the Committee's consideration.

Alberta Health has also appointed Sharon Snell as a provincial nursing consultant who reports to the Deputy Minister of Health and will address current and future concerns associated with nursing personnel. Ms. Snell will also be responsible for developing and coordinating the implementation of government initiatives concerning nursing personnel, establishing contact with key nursing stakeholder groups and monitoring nursing developments in the service and educational sectors.

Concerns as to the Government's Move to Put Nurses on Boards

Although the Commission wishes to enhance communication among nurses and between nurses and other health providers and decision makers, the Commission feels it is inappropriate to have an employee of a hospital sit on the board. This could well undermine the authority and effectiveness of the hospital management by enabling "end runs" directly to the board before management has had the opportunity to study the situation and implement solutions. This could also result in a board whose main purpose is policy formulation, decision and stewardship of the funds to become involved in day-to-day management and administration of hospital affairs, which is the realm of management. Employees representing other health providers may also now request a representative on the board. Nursing staff, however, make up 70% to 80% of hospital staff.

Traditionally, board members are not there as representatives of other groups, but are appointed to represent the general public interest. A nursing representative on the board, who is appointed as a representative of nursing only, may wish or have to consult with nurse colleagues before casting a vote at board meetings. This might adversely affect the conduct of board business.

SUMMARY OF RESPONSES BY INDIVIDUALS AND ORGANIZATIONS TO THE INTERIM REPORT ON NURSING

The Commission received 46 responses to the Interim Report on Nursing — 22 from individuals and 24 from organizations. Most, but not all commented on all of the recommendations. Following is a summary of these responses.

Recommendation A.1: Department of Advanced Education provide increased funding to the Universities of Alberta, Calgary and Lethbridge to enable them to increase encrollment quotas in basic and post-basic programs.

Responses to Recommendation A.1: About half of those who submitted felt that a university degree would only be necessary for certain specialized kinds of nursing, and that there should be increased funding for nursing, but that this should not necessarily replace R.N. and R.N.A. qualifications completely. Many people were concerned with the availability of such education, particularly in rural areas, and with the means of upgrading to this level for nurses currently employed. Even those who did not feel a baccalaureate degree was essential for all nurses, thought that more funding was needed for nurses to attend educational programs, and that self-motivated education should be rewarded. One group felt that colleges and universities should work jointly in increasing and improving baccalaureate education.

Recommendation A.2: That within 2 years the Faculties of Nursing initiate and evaluate a nurse internship pilot project whereby new graduates are paid a salary while enhancing their clinical skills. This should include a mixture of rural and urban experience.

Responses to Recommendation A.2: About three-quarters of the submissions were in favour of a nurse internship program. A few responses from schools indicated that, as they already provide in-depth clinical practice components, such an internship program would be unnecessary. Some felt that investment of training time on the job, and comprehensive orientation programs would be more appropriate. Almost all agreed that nursing practice and nursing education needed to work more closely together.

Recommendation A.3: That the Alberta Association of Registered Nurses actively support the implementation of the Canadian Nurses Association's certification program for the various clinical specialties in nursing.

Responses to Recommendation A.3: Almost everyone who wrote to us agreed that there should be a certification program for clinical specialties in nursing. Two associations pinpointed gerontology, long-term care, and psychiatry as important specialties. Hospitals said that flexibility would be important, and also a greater financial reward than exists at present. Two hospitals indicated that National Certification would be essential. Most of the responses indicated that certification programs should not replace University education, and that responsibility for these programs would have to be given to the correct department.

Recommendation A.4: That the Department of Advanced Education through such bodies as the Alberta Council on Admissions and Transfer collaborate with the appropriate educational institutions and professional associations to establish a mechanism for consistent crediting of appropriate courses and experience for transfer from one type of nursing program to the next.

Responses to Recommendation A.4: All but one of the responses gave support to the recommendation, at least in theory. About half qualified it by saying that the diversity of programs would make it difficult to credit education from one institution to another. One hospital suggested challenge exams as a possibility. Educational institutions felt that the recommendation might be impossible to implement without courses losing their individual uniqueness.

Recommendation A.5: That funding of continuing nursing education programs be increased by the year 1990. Responsibility for funding continuing education programs must rest jointly with individual nurses, employers, post-secondary educational institutions, professional bodies, collective bargaining associations, and the appropriate departments of government, with the Minister of Advanced Education taking the lead role.

Responses to Recommendation A.5: Over three-quarters of the responses were in agreement with this recommendation. Most of these felt that there should be some funding for continuing education, but that some of the costs should be paid by the nurses themselves. One hospital said that it must be supported as an ongoing process, and if at the end of five years nurses had not availed themselves of programs, these programs should be reviewed. One commented that "formal programs" should be defined by the Commission. A few hospitals indicated that continuing education would require a multi-disciplinary health care team approach, which does not exist at present.

Recommendation A.6: That the Alberta Association of Registered Nurses institute a policy of mandatory continuing education for nurses to update their knowledge and skills in order to retain their active registration status.

Responses to Recommendation A.6: Most hospitals and nursing organizations had reservations about the desirability and feasibility of this recommendation. While they agreed with it in principle, they commented that mandatory continuing education has proven ineffective in the past. Medical organizations were concerned with the costs. They also commented that the profession is so diversified that the programs would have to be equally diverse. As it is currently difficult to pursue continuing education programs, there must be some indication of how nurses are to be given this opportunity.

Recommendation A.7: That individual nurses who are evaluated by their supervisors as having provided superior performance or demonstrated outstanding expertise be rewarded accordingly.

Responses to Recommendation A.7: About two-thirds of the individuals and organizations who responded felt that the recommendation was fine in theory, but would be next to impossible to implement, with a strong reaction from unions. Many felt that in order to prove credible, educational performance would have to involve complex rating systems, which would need to be very specific in their criteria. Individual submitters requested further clarification of "clinical laddering". In general people felt that "superior performance" and "outstanding expertise" would be open to individual interpretation and that the process might even create a situation in which people would exploit others in order to achieve recognition.

Recommendation B.1: That all hospitals and nursing homes be required to review working environments to ensure that they are safe and secure, and that procedures are in place to deal with hazardous or crisis situations, and that the procedures and appropriate training be provided to staff.

Respones to Recommendation B.1: Almost everyone agreed with this recommendation, but some felt that the recommendation itself was too vague to be of much use. The following were general qualifications to the recommendation:

— A broader perspective of health facilities should be considered.
— There should be mention of the danger resulting from the abuse of the availability of drugs, AIDS and intruder aggression.
— There is a need for provincial standards.

Recommendation C.1: That the Department of Hospitals and Medical Care (now Alberta Health) evaluate the current nursing staff guidelines used by the Department. Once established, those guidelines should be provided to hospitals and nursing homes for their information.

Responses to Recommendation C.1: Almost everyone agreed with this recommendation. Many organizations felt that it should be jointly planned by government and the nursing profession, since, as medical attention is being directed to increasingly diversified realms, nursing must do the same. Submissions indicated that manpower must be reviewed. Various people suggested that individual hospitals should be responsible, that variable staffing may be a problem, or that current programs would be diluted to this end.

Recommendation C.2: That hospital management use patient classification systems and admission monitoring systems as guidelines only, and in conjunction with personal judgement, to assign staff and patients.

Responses to Recommendation C.2: Response to this recommendation was diverse and of an extremely general nature. Some felt that such guidelines were already in place. Almost all organizations and individuals agreed with this recommendation, and felt that there was a need for patient classification, possibly province wide. Most felt that this must be done based on patient need. A few submissions suggested that the reference to professional judgement was vague. Some felt that such guidelines inevitably dealt with money rather than patient care. One group questioned the term "guideline" (i.e. felt that there should be more than guidelines).

Recommendation C.3: That hospital and nursing home managers and collective bargaining associations introduce ways to increase the flexibility of work schedules.

Responses to Recommendation C.3: Most submissions were in favour of innovative staffing approaches, but felt that these approaches might be costly. Some warned that the unions might have difficulty agreeing with it. Nursing organizations stressed increased vacation time. One individual suggested that all groups involved in hospital administration must work toward implementing this recommendation.

Recommendation C.4: That the Alberta Hospital Association create regional councils comprised of representatives from hospital boards and professional associations to clarify "grey areas" of authority, accountability, and responsibility among nurses, physicians, and other health care providers.

Responses to Recommendation C.4: About three-quarters of those who responded disagreed with this recommendation. Many felt that such a council would further complicate an already complicated system, and create another body without accountability; and that ultimately such a council would increase, not diminish grey areas of authority. A few felt that such a council should not be medically oriented. Certain organizations said that a better solution would involve improved communication between nurses and hospital boards.

Recommendation C.5: That the government encourage pilot projects involving private nursing companies which would contract their services to an entire hospital or a nursing home, or particular units within a hospital or nursing home.

Responses to Recommendation C.5: Almost everyone disagreed with this recommendation. Criticisms included:

— profit becoming a governing factor in nursing;
— comparison with the American health care system;
— that it contradicts recommendation C.5; and
— that it would further fragment the system.

A few people felt that it would give a competitive edge that the profession needs. Those who accepted the recommendation felt that if implemented it would require close follow-up and more definition than is given in the recommendation.

Recommendation C.6: That representatives of health care providers appoint, with government, on a five-yar trail basis a health Ombudsman/Advocate to document and investigate complaints from nurses and other health care providers.

Responses to Recommendation C.6: Most submitters expressed reservations about this recommendation for the following reasons:

— that it would be unnecessary as AARN and Unions provide this service;
— that it did not deal with institutional and staff responsibility; and
— that it further diffused authority and accountability.

Some supported the Ombudsman as a pilot project, or if correction of the current situation in nursing was to be attributed to this Ombudsman.

APPENDIX VI

The Commission received comments on the Interim Report from the following organizations and individuals.

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Alberta Community Health Nurses Society
Alberta Hospital Association
Alberta Long Term Care Association
Alberta Medical Association
Charles Camsell General Hospital, Ad Hoc Committee Staff Nurses
Co-ordinators of Nursing Education in Calgary Health Care Agencies
Community and Occupational Health
Council of Teaching Hospitals of Alberta
Edmonton and District Nursing Administrators Committee
Executive Nurses Association of Alberta
Medicine Hat Nurses Education Committee
Misericordia Hospital
Olds General Hospital and Auxiliary Hospital and Nursing Home District No. 26
Red Deer Regional Hospital Centre
Rimbey General & Auxiliary Hospital
Royal Alexandra Hospital
Society of Community Health Nursing Supervisors of Alberta
Sturgeon Health Unit
United Church of Canada, Alberta and Northwest Conference
United Nurses Association, Local #79, Nursing Concern Committee
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APPENDIX VI

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APPENDIX VI

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United Nurses of Alberta, Local 92
United Nurses of Alberta, Local 106
United Nurses of Alberta, Local 113
United Nurses of Alberta, Local 120
United Nurses of Alberta, Local 141
United Nurses of Alberta, Local 143
United Nurses of Alberta, Local 152
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APPENDIX VII
PROVINCIAL HEALTH CARE COMMISSIONS AND COMMITTEES

Committee:	**The Advisory Committee on the Utilization of Medical Services — Alberta**
Chair:	**Dr. M. Watanabe**
Term:	**September 1987 - September 1989**
Mandate:	**To follow up on the recommendations of the 1985 Utilization Committee Report and to advise the Minister of Health on ways to reduce or control increases in the use of medical services.**

Terms of Reference:

— To advise on the implementation of the recommendations of the Utilization Committee Report related to reducing or controlling increases in utilization of medical services;

— to propose strategies for achieving cost-efficient methods of delivering health care services that are consistent with goals for health care in Alberta;

— to review physician manpower statistics and the relationship to health care utilization and costs;

— to advise on strategies to achieve optimal physician numbers and distribution in Alberta; and

— to advise on such matters as may be referred to the committee by the Minister from time to time or with the agreement of the Minister, as may be recommended by the Committee.

A copy of the Report of the Advisory Committee on the Utilization of Medical Services is located with the working papers of the Premier's Commission on Future Health Care for Albertans as outlined in the Materials Guide. A summary of the Report — An Agenda for Action — appears in Appendix IX, on page 65.

APPENDIX VII

Committee: **Alberta Nursing Home Review Panel**

Chair: **Dr. Harry A. Hyde**

Term: **April 1981 - March 1982**

Mandate: **To review the nursing home system in Alberta and make appropriate recommendations.**

Terms of Reference:

- To assess the development of the nursing home system in Alberta;
- to compare the Alberta nursing home system with those in other provinces;
- to evaluate the structure, functioning and financing of nursing homes in Alberta; and
- to report its findings and recommendations to the Minister of Hospitals and Medical Care.

A copy of the recommendations of the Alberta Nursing Home Review Panel is located with the working papers of the Premier's Commission on Future Health Care for Albertans as outlined in the Materials Guide.

Committee: **The Health Minister's Advisory Committee on Wellness and Health Promotion — British Columbia**

Chair: **Patricia D. Wolczuk**

Term: **June - December 1988 (members still meeting with the Minister; the Minister is reviewing report with Cabinet)**

Mandate: **To develop a document that establishes a vision and goals with respect to the health status of British Columbians; and to develop a health promotion plan for British Columbia.**

Terms of Reference:

- To focus within a broad prospective;
- to use the "second opinion" viewpoint, with goals beyond this view; and
- to ensure maximization of all resources.

APPENDIX VII

Committee: "Health Advisory Network" Steering Committee — Manitoba

Chair: Dr. Arnold Naimark

Term: Ongoing from December 1988; Steering Committee and Task Forces will have 4 - 6 month life spans.

Mandate: To obtain advice through cooperative deliberation among representatives of various facets of the health care community on organization, administration and financing of six specific health aspects through establishment of task forces on:

1) teaching hospitals cost review;

2) Winnipeg hospital role definition (programmatic basis);

3) extended treatment bed review/re-examination (to upgrade by 60 from 340 beds);

4) rural health services;

5) northern health services (inclusive of status Indians); and

6) health services for the elderly.

Terms of Reference:

— To undertake such investigation and analysis of specific issues in the organization, administration and financing of health services, as may be referred to the Committee by the Minister, or as the Committee may deem appropriate, and to report thereon to the Minister;

— to establish Task Forces to use such other means as may be deemed appropriate by the Committee for the purpose of undertaking the investigations and analyses required by the Committee in order for it to tender soundly based advice; and

— to inform both the general public and the health services community about the matters being addressed by the Health Advisory Network.

APPENDIX VII

Commission: **Commission on Selected Health Care Programs — New Brunswick**

Co-Chair: **E. Neil McKelvey, Q.C., Sister Bernadette Levesque, RN**

Term: **January 1989 - June 1989**

Mandate: **To review selected health care programs in the province and to report the findings and to make appropriate recommendations related to the Terms of Reference.**

Terms of Reference:

— To examine the service mandates and management models of specific components of the current health care system (hospitals, medicare and the drug programs), and the interrelationships between the components insofar as they affect the cost of the components;

— to examine utilization of hospital services, medicare and prescription drug programs and the growth rates in these programs and to identify possible options that would allow for better cost containment;

— to examine the costs associated with each of the specific components and the current methods of funding and to identify possible options that would allow for better allocation and use of all available resources;

— to assess the level of funding for these programs and make comparisons with other jurisdictions;

— to report findings and make recommendations consistent with the public interest and the general welfare of the Province of New Brunswick on how the health care services can be better structured, organized and then distributed so that the various components of the system can function in the most efficient and cost effective manner; and

— to submit the completed report to the Government of New Brunswick within a six month time frame.

A copy of the recommendations of the Commission on Selected Health Care Programs is located with the working papers of the Premier's Commission on Future Health Care for Albertans as outlined in the Materials Guide.

APPENDIX VII

Commission: **Royal Commission on Hospital and Nursing Home Costs — Newfoundland**

Chair: **David B.Orsborn**

Term: **April 1983 - February 1984**

Mandate: **To hold an enquiry into the matters related to the reasons for increasing costs in hospitals and nursing homes and on the efficiency or otherwise of these institutions and to make recommendations for improved efficiency and for the generation of additional revenue.**

Terms of Reference:

— To determine the reasons for hospital and nursing home costs increasing at a rate higher than the normal rate of inflation;

— to determine the appropriate level of funding required by hospitals and nursing homes to operate currently approved services;

— to project the increases that will occur in hospital and nursing home costs for the next five years for currently approved services and future planned services as outlined in the Five-Year Plan;

— to recommend what operating efficiencies may be achieved in hospitals and nursing homes, individually and collectively, by streamlining systems, sharing services or other areas;

— to recommend appropriate levels of services and/or appropriate alternatives for program reductions;

— to recommend appropriate measures for the generation of revenues to meet growing hospital and nursing home costs; and

— to report on the findings by February 15, 1984.

A copy of the recommendations of the Royal Commission on Hospital and Nursing Home Costs is located with the working papers of the Premier's Commission on Future Health Care for Albertans as outlined in the Materials Guide.

APPENDIX VII

Commission: **The Nova Scotia Royal Commission on Health Care**

Chair: **Mr. J. Camille Gallant**

Term: **Fall 1989**

Mandate: **To examine the financing and delivery of health services in the province.**

Terms of Reference:

— To examine present costs of the health care delivery system, and recommend efficiencies which may be adopted to reduce costs while maintaining the effectiveness of the present programmes without imposing hospital user fees or direct charges for physicians' services;

— to examine the rates of increase in the cost of health care, including hospital care, medical services insurance, ambulance services, community health and drug dependency programmes, and to the extent possible identify the reasons for such increases;

— to examine duplication of services and recommend methods to improve efficiency;

— to assess the present and future physician manpower requirements of the Province;

— to assess administrative efficiencies of hospitals and make recommendations respecting alternative practices which would permit optimum efficiency in the hospitals and hospital system of the Province;

— to assess the costs incurred by teaching hospitals in respect of their responsibilities to medical schools and students; and

— to report the evidence and findings of such inquiry to the Executive Council and make recommendations thereon.

A copy of the report of the Nova Scotia Royal Commission on Health Care is located with the working papers of the Premier's Commission on Future Health Care for Albertans outlined in the Materials Guide.

APPENDIX VII

Committee: **Minister's Advisory Group on Health Promotion — Ontario**

Chair: **Mr. Steve Podborski**

Term: **October 1984 - October 1987**

Mandate: **To develop and recommend health promotion directions and strategies for the province of Ontario**

Terms of Reference:

— To advise on methods of ensuring effective coordination between government and non-government agencies, programmes and services which deliver or have potential for health promotion;

— to make recommendations on effective promotion approaches and projects - either through new initiatives or through modification of existing activities;

— to liaise with key groups in the private sector to identify opportunities for cooperative action; and

— to pursue such other tasks as may be assigned from time to time by the Minister.

A copy of the recommendations of the Minister's Advisory Group on Health Promotion is located with the working papers of the Premier's Commission on Future Health Care for Albertans as outlined in the Materials Guide.

APPENDIX VII

Committee:	**Ontario Health Review Panel**
Chair:	**John R. Evans, M.D.**
Term:	**November 1986 - June 1987**
Mandate:	**To review and recommend a general direction for health in Ontario and to identify some specific issues to be examined further in order to strengthen, improve and guide the evolution of health and health care in the Province of Ontario.**

Terms of Reference:

— To examine the changing patterns of health services in Ontario, and trends in health manpower and technology, in relation to changes in the demographics and health profiles of the citizens of Ontario;

— to examine incentives and mechanisms to maintain the quality and accessibility of health services, to encourage the most effective and economical use of health resources, and to stimulate greater attention to the promotion of health and prevention of disease;

— to examine the relationship between health care professionals and the government with a view to maintaining professional autonomy; and

— to attempt to identify policies of high priority and to indicate a process for a subsequent stage of in-depth examination of the options for implementation of these policies.

A copy of the recommendations of the Ontario Health Review Panel is located with the working papers of the Premier's Commission on Future Health Care for Albertans as outlined in the Materials Guide.

Committee:	**Panel on Health Goals for Ontario**
Chair:	**Robert Spasoff, Ph.D.**
Term:	**November 1986 - August 1987**
Mandate:	**To provide advice to the Minister...regarding health goals for Ontario.**

Terms of Reference:

— To link the proposed goals to appropriate data and stated in a way which will facilitate planning for their achievements; and

— to suggest mechanisms to track progress toward the achievement of the goals.

A copy of the recommendations of the Panel on Health Goals for Ontario is located with the working papers of the Premier's Commission on Future Health Care for Albertans as outlined in the Materials Guide.

APPENDIX VII

Committee: **The Premier's Council on Health Strategy — Ontario**

Chair: **Hon. David Peterson, Premier**

Term: **Not Specified**

Mandate: **To develop a long term strategy for health in Ontario.**

Terms of Reference:

— To select specific goals for the achievement of improved health

— to recommend public policy initiatives to improve the health status of Ontario residents;

— to recommend innovative approaches to health care; and

— to advise and assist in establishing criteria for provincial "Health Innovation Fund" and monitor the performance of projects approved for funding.

Commission: **Commission of Enquiry on Health and Social Services — Quebec**

Chair: **Dr. Jean Rochon**

Term: **January 1986 - December 1987**

Mandate: **To evaluate the operation and financing of the health and social services system in meeting its objectives.**

Terms of Reference:

— To evaluate the operation and finances of the health and social services system in meeting its objectives;

— to study the various solutions possible to different problems inherent in the system; and

— to make appropriate recommendations to government in order to ensure the maintenance and development of the services.

A copy of the recommendations of the Commission of Enquiry on Health and Social Services is located with the working papers of the Premier's Commission on Future Health Care for Albertans as outlined in the Materials Guide.

APPENDIX VII

Commission: **Saskatchewan Commission on Directions in Health Care**

Chair: **Dr. Robert Murray**

Term: **June 1988 - December 31, 1989** (extended to March 1990)

Mandate: **To conduct a review of Saskatchewan's health care system and to recommend policy options on improvements in delivery, efficiency and overall management of the system.**

Terms of Reference:

The Saskatchewan Commission on Directions in Health Care will have responsibility to inquire into and report on the future health care requirements of the residents of Saskatchewan, and appropriate means by which those requirements may be met, including but not limited to the following areas:

— institutional, treatment and support services (such as hospitals, special care homes, ambulance and home care);

— insured services (such as medical services, dental services and drugs);

— community health services (such as public health services, mental health services and health promotion);

— the impact of social factors on the needs, delivery and costs of health care (such as demographic trends, changing lifestyles and consumer expectations);

— the supply, education, qualifications, roles and distribution of health care facilities and services;

— the nature and distribution of health care facilities and services;

— the efficacy and cost-effectiveness of new technology in diagnoses and treatment;

— the organization and delivery of health care services, with emphasis on the equality of access and cost-effectiveness;

— the communication of health information, illness prevention and the education of the public in personal health matters;

— the assurance of quality in all aspects of health care;

— the utilization of heath care services; and

— funding processes for health care services.

In conducting the inquiry, the Commission:

— will receive briefs, both written and oral, from individuals and organizations;

— will organize and conduct public hearings in such places as the Commission believes necessary to allow the public a reasonable opportunity to present their views; and

— may seek such other advice as deemed necessary.

The Commission will submit such interim reports as required and will submit its final report and recommendations on or about 31 December, 1989 (extended).

APPENDIX VIII
CARING AND RESPONSIBILITY
A STATEMENT OF SOCIAL POLICY FOR ALBERTA (1988)

[Editor's Note: The following statements are reproduced from the original publication]

Role of Government

It is the role of the Government of Alberta:

— To foster a social, economic, political and cultural environment in which Albertans are able to participate fully in their society;

— To promote a dignified and humane society in which Albertans are assured high standards of education, health, personal safety and security, and protection of their fundamental freedoms;

— To foster individual self-reliance and provide positive opportunities for individuals to achieve their personal goals, to take responsibility for their actions, and to be contributing and caring members of Alberta society;

— To promote a society which respects the beliefs, values, worth, and contributions of all individuals and allows them to participate fully in all aspects of Alberta life;

— To provide equitable opportunities for all Albertans, on the basis of their needs, to access government programs;

— To ensure that Albertans have access to quality programs and services in essential areas of government responsibility such as education, health care, and justice;

— To provide special programs and support to those who, for a variety of reasons, may need either temporary or permanent assistance;

— To foster and support a social and economic environment in which Alberta continues to grow and prosper, while generating the resources necessary for the implementation of effective programs and services for Albertans;

— To foster the growth and enrichment of Alberta's cultural heritage in an environment which supports the development of the artistic and cultural talents of Albertans, and to support recreational and leisure activities which contribute to the quality of life in Alberta;

— To protect the environment of Alberta and to ensure that government policies are directed toward enhancing its natural beauty and quality;

— To demonstrate good stewardship over the resources of Alberta in the best interests of present and future Albertans; and

— To work cooperatively with the federal government, other provinces and municipal governments in areas of shared responsibility in order to ensure that the needs of Albertans are addressed and that they receive their fair share of benefits and support.

These important statements describe both the role and the challenges that face this government. Fulfilling these roles requires the deliberate and dedicated actions of a government committed to building a strong future for Alberta. Just as importantly, meeting these challenges requires the full and active participation of all Albertans.

Responsibility of Government

Within the context of both the statement of social policy and the role of government which have been articulated, government must review the various programs and policies it has developed. Principles have been developed to guide the review of existing programs, and the identification and implementation of new programs.

Principles

— Government policies and programs must promote and facilitate individual initiative and self-reliance, self-sufficiency and responsibility.

— Government policies and programs must recognize the paramount importance of the family as the basic unit of our society and the diversity of family structures, and must support and strengthen the role of the family in Alberta society.

— Government policies must enable individuals, families and communities to build on our strong tradition of volunteerism, and to take increasing responsibility for caring for themselves and for those in need of help and support.

— Government policies and programs should involve, to the extent possible, communities and community agencies in the development, delivery, and evaluation of services to Albertans.

— Government policies and programs must support and complement private business, industry and community agencies, and provide an environment in which the private sector can work cooperatively with government in meeting the needs of Albertans.

— Government policies must support the individual's ability to make choices and decisions.

— Government policies and programs must be adaptable and responsive to the changing needs of Albertans.

— Government policies and programs must focus on the development of strategies that address the causes of social and health problems and the ways of preventing their occurrence.

— Priorities for government services and programs should be established on the basis of responding to the greatest needs; should take into consideration the financial circumstances of the individuals affected; and, where possible, should be designed to help individuals regain their self-sufficiency and independence.

— The development of policies and programs must involve Albertans actively in describing issues and in considering alternatives; and once policies are developed, Albertans must be well informed about the programs and services available to them.

— Government policies and programs requiring inter-departmental cooperation must operate without duplication and as smoothly as possible for the consumer.

APPENDIX IX
A SUMMARY OF THE REPORT OF THE ADVISORY COMMITTEE ON THE UTILIZATION OF MEDICAL SERVICES (1989)

[Editor's Note: The following summary was reproduced from the Advisory Committee's Report.]

Our terms of reference called on the Advisory Committee to look at many issues some of which were quite specific and others which were broader in nature. The results of our investigations are summarized in a report running over 140 pages and containing 132 specific recommendations. The recommendations, which can be found throughout the report and again listed in Appendix 10, are in some cases very narrow and specific and in others, call for sweeping changes in Alberta's health care system. If the Advisory Committee were to select themes or concepts arising out of our work that capture the spirit of our deliberations, they would include the following:

1. **Need for ongoing monitoring of utilization of medical services.**

   The Advisory Committee has found that since 1987, there as been a decline in the rate of increase in the use of medical services and for some specific services, actual decreases in the rate of utilization. This is the first such plateau seen since 1982 and to our knowledge is a phenomena that has not been experienced in other provinces in Canada. We cannot be certain why utilization has modulated but we think it may be due in part to the attention focussed on utilization issues by the Advisory Committee and stakeholder groups such as the College of Physicians and Surgeons (Alberta) and the Alberta Medical Association. As well, we believe that the spirit of cooperation which has existed in the past between the Government of Alberta and the medical profession has created an atmosphere where change can occur. In order to maintain the momentum of the Advisory Committee, we have recommended that a permanent Monitoring Committee be put into place composed of representatives of stakeholder groups to ensure that the use of medical services continues to be examined and issues of concern brought to the attention of practitioners and the public.

2. **A comprehensive communications strategy for public dialogue on health issues.**

   Correct and easily understandable information is essential to any effort to change the way that providers and patients use our health care system. If we are correct in our assumption that the focus on utilization issues created by the Advisory Committee had some impact on modulating utilization rates, then it demonstrates the importance of ongoing communication with health care providers and with the public. The Advisory Committee has therefore recommended that the Minister of Health establish a Communications and Community Advisory Committee to serve as an advocate for good health and community involvement, as well as being the source of reliable health information. Its principal task will be to advise the Minister on the development of health promotion campaigns, create greater public awareness of health costs, and encourage the appropriate use of health services. Together with stakeholder groups, and with the support of the proposed Monitoring Committee, it is our view that the Communications and Community Advisory Committee can play an important role in bringing to the attention of practitioners and the public significant health and utilization trends which require attention.

3. **Need for goals and objectives for Alberta's health care system.**

   In the 1989/90 fiscal year, Alberta will spend nearly $3.5 billion on health care, yet goals and objectives for this very large public expenditure program are not clearly articulated or easily accessible. Goals and objectives are essential to guide and plan Alberta's health care system and to serve as a benchmark for evaluation. The Advisory Committee has therefore recommended that the Minister of Health ask the Universities of Alberta and Calgary, together with Alberta Health, to convene a conference in the spring of 1990 with representatives of all stakeholder groups throughout the province to attempt to achieve consensus on goals for the health care system and to develop strategies for the delineation of specific and measurable objectives related to each goal. It is proposed that such conferences be held biannually in order to regularly refine goals and objectives previously set and to evaluate progress in their attainment.

4. **Better information on the health status of Albertans and on utilization patterns is needed.**

At present, Alberta does not have adequate information on the health status of its citizens either in aggregate or by regions, ethnic groups, or age groups. As well, the Advisory Committee was frequently hindered in its work because data on utilization patterns was either not available or was prohibitively expensive to obtain. Many of our health data bases were designed for purposes other than utilization monitoring and thus, accessing data is frequently cumbersome. With the existing horizontal organization of our health care system, the maintenance of separate data bases by different sectors in the health care system which are not integrated with each other make it impossible to obtain a comprehensive view of utilization patterns. In many cases, data is not recorded in the same way by different sectors of the health care system. The Advisory Committee has therefore recommended that all medical services, regardless of where they are performed, be counted and recorded by uniform methods and that an efficient information retrieval system be developed to assure that data about health care use is current and of good quality. We have also recommended that health status data be regularly collected for evaluation and planning purposes.

5. **Significant enhancement of health services evaluation and research activities is required.**

While Alberta has been a leader in funding biomedical research, there is inadequate support for research into health services with respect to cost effectiveness, alternative delivery systems, quality of care, outcomes and effectiveness of care, technology assessment, epidemiology, and development of health promotion and prevention strategies. Traditional biomedical funding sources have directed their funds to basic and clinical research. There is also a shortage of expertise in health services research. The Advisory Committee has recommended that the Province of Alberta establish a health services research agency, similar to the Alberta Heritage Foundation for Medical Research, and redirect at least 1% of annual public expenditures on health care to this agency to fund health services research and program evaluation initiatives.

6. **Increased support for ambulatory care and non institutional care is encouraged.**

The focus of our health care system in this century has been the acute care hospital. Hospital care for many forms of illness is extremely expensive and is not always necessary. Recent developments have allowed many forms of care to be provided on an outpatient basis or in the home, thereby avoiding the need to be admitted to hospital. The Advisory Committee has therefore recommended that Alberta Health encourage, through the use of funding incentives, a shift from inpatient care to ambulatory care and home care where clinically appropriate and economically desirable. Such a shift should occur through transfer of funds now used for inpatient activities to support these new thrusts. To help ensure that such developments occur in an orderly and planned fashion, we have recommended that there be legislation requiring the registration of such facilities.

7. **There is a need for better information on manpower to assist in planning.**

The Advisory Committee found that there are significant discrepancies between different data bases on physician numbers currently used for manpower planning activities. Moreover, such counts do not take into account time spent by physicians in non-clinical activities such as research, teaching and administration. Similar issues arise in examination of nursing manpower issues. Suggestions of a nursing shortage at a time when more nurses are working than ever before suggests that a greater number of nurses are working in part-time positions. In the face of inadequate and at times conflicting data, the Advisory Committee has concluded that there is not sufficient good information to draw conclusions on the relationship between physician manpower and the use of medical services or for manpower planning purposes in medicine, nursing , and other disciplines. We have therefore recommended that a Centre for Health Manpower Studies be established, under the guidance of an Advisory Committee, to monitor manpower supply and develop new and accurate manpower measurements.

The above represent highlights or major themes contained in the report of the Advisory Committee. The complete report contains much more detail and many additional recommendations. The report in total constitutes, in a sense, a strategic plan for Alberta's health care system.

There is little value in identifying opportunities for positive change unless those changes are implemented. Unless a structure and an approach is put into place to address these recommendations, the time, energy, and commitment of the many people involved directly and indirectly in our work will have been lost.

Happily, some initiatives arising from the Committee's recommendations are already underway. A committee has been formed to study the acute care hospital funding system and propose improvements. A trial is underway to link Alberta's Health Care Insurance Plan data with Hospital data at the Red Deer General Hospital to obtain a comprehensive look at use of laboratory services in that region.

Many of our recommendations call on Alberta Health, together with stakeholders, to form committees or task forces to address specific recommendations contained in this report. We are convinced that cooperation between government, health care providers , and the Alberta public is necessary if meaningful change is to be successfully implemented.

While it will clearly rest with the Minister and Alberta Health to develop the most appropriate structure, the Advisory Committee urges that specific persons and sections in Alberta Health be designated responsible for implementation of specific recommendations. We suggest that Alberta Health institute a steering committee to assign priorities and serve as a coordinating and facilitating body. And finally, we encourage the Minister of Health to begin discussions with all stakeholder groups with respect to this report in order to test reactions and to engage their interest, support, and acceptance for our recommendations.

APPENDIX X
ESTABLISHED PROGRAMS FINANCING

1. Background

The Established Programs Financing (EPF) is the largest federal/ provincial transfer program. The cash portion of the transfer is nine billion dollars which accounts for 7.7% of the estimated federal program expenditure in 1989/90. The table on page 70 shows Alberta's total EPF entitlements since 1977/78. The purpose of EPF is to assist provinces in the financing of health and post-secondary education services. The "block fund" nature of the arrangement allows the provinces to allocate these funds according to their own priorities.

EPF transfers are determined by a formula set out in the fiscal arrangements act. Transfers are provided on an equal per capita basis and accelerated by nominal growth of the economy and provincial population. Federal legislation provides that annual total EPF entitlements shall not grow less than the rate of inflation.

Alberta's Concerns Regarding Established Programs Financing

1. Under the pre-1977 cost-sharing arrangements, the federal government paid approximately 50% of the province's hospital insurance, medical care, and post secondary education costs. By the mid-1970's the cost sharing arrangements had become technically difficult to administer and were displaying a number of other problems:

   a) The open-ended nature of the cost-sharing arrangements reduced the federal government's ability to control and predict its expenditures.

   b) Wide per capita variations and federal transfers in different provinces appeared inequitable.

   c) Cost sharing of specific expenditures led to program rigidities.

   d) The approach encouraged inefficient spending by both orders of government to gain access to the "fifty cent dollars."

   The solution to the problems associated with cost-sharing was an EPF block fund approach for hospital insurance, medical care and post-secondary education (i.e., the "established" programs). The transfer consisted of a per capita cash payment representing half the national average federal payment per capita in 1975-76 under the old cost-sharing arrangements, plus the transfer of 13.5 personal income tax points and 1.0 corporate tax point. All provinces were guaranteed total transfer (cash plus tax) that equaled at least twice the value of the cash payment. Because Alberta had increasing tax revenue in the late 1970's our total transfer eventually became more than twice the value of our cash payment. The surplus was known as the "fiscal dividend."

2. In 1982, the revenue guarantee from the federal government which had been an integral part of EPF was terminated. This action is expected to cost provinces an estimated $5.3 billion over the 5 years beginning in 1982. Also in 1982, technical changes were made which ensured that EPF transfers to all provinces would be exactly equal per capita. This eliminated Alberta's fiscal dividend at a 5 year estimated cost of $504 million.

3. In 1983, the federal government placed a 6% and a 5% cap on the post-secondary education component of the transfer for the 1983/84 and 1984/85 fiscal years, respectively. Although the post-secondary education component was returned to growing at the rate of the economy 1985/86, the provincial revenue lost through 6 and 5 will never be made up because the base has been permanently lowered.

4. In 1984, the Canada Health Act set certain conditions relating to the health care transfer under EPF and introduced dollar for dollar penalties against user fees and extra billing by the provinces. Until Alberta abolished extra billing and user fees, Alberta's penalties ran at approximately $12 million per year.

5. Effective fiscal 1986/87, the federal government unilaterally reduced the growth rate of the total EPF entitlement to nominal GNP - 2%. This is expected to reduce Alberta's cash entitlements by a cumulative total of $536 million for the period 1986/87 to 1990/91.

6. A change in the formula for calculating EPF payments for the 1990/91 fiscal year was announced in the April 1989 budget.

   At present the formula is known as "GNP - 2" and will be changed to "GNP - 3." For fiscal years 1990/91 and 1991/92, this measure is estimated to reduce Alberta's revenue by a cumulative total of $60 million, compared to what would have been received under GNP - 2. The federal provincial financial arrangements come up for renegotiation in 1992.

Conclusion

The conclusion from reviewing the EPF data and reviewing the practice of the federal government over the last number of years with respect to other programs, is that the federal government is gradually withholding funds and not giving provinces the flexibility for cost recovery and programs delivery. In addition, while the federal government tries to enforce federal standards for health care, it does not appear to be prepared to make the financial commitment necessary to allow the provinces to comply. In 1977, the federal government's share of payments for health care was 50%. In the 1988/89 fiscal year, the proportion declined to 42%. The federal government is in a fiscal crisis and large transfer programs are obvious targets for reductions.

This reduced funding could have a marked impact on funding of health care in Alberta in the next 20 years. As costs continue to rise and revenues shrink, very difficult choices will have to made by provincial governments in the future. Either the costs to Albertans will rise substantially or services will have to be rationed to meet these ever increasing costs and decreased revenues.

Because of an aging population and increased technology cost pressures, there will be a shift towards expensive health care.

APPENDIX X

EPF TRANSFERS TO ALBERTA - CASH AND TAX 1977/78 TO 1990/94

Year	$Million	%change	Notes
1977/78	550		Block funding started
1978/79	652	18.5	
1979/80	789	21.0	
1980/81	944	19.6	
1981/82	1117	18.3	
1982/83	1167	4.5	Revenue Guarantee eliminated plus all transfers on equal/capita basis
1983/84	1280	9.7	6% + 5% ceiling on post-secondary transfer for 83/84 and 84/85; revenue lost because base lowered
1984/85	1364	6.6	
1985/86	1463	7.3	GNP - 2 Introduced
1986/87	1566	7.0	
1987/88	1644	5.0	
1988/89	1731	5.3	
1989/90	1839	6.2	
1990/91	1942	5.6*	Formula to change from GNP-2 to GNP-3
1991/92	2023	4.2	
1992/93	2094	3.5	
1993/94	2162	3.2	

*Based on measures in April 1989 budget which changes the formula beginning in 1990/91.

Source: Federal Finance

APPENDIX XI
A COMMENT ON VOLUNTEERS IN THE HEALTH SECTOR IN ALBERTA

For many years, Albertans have shown concern for some of us by volunteering their services. We should feel proud of our volunteer efforts.

According to a recent survey by Statistics Canada entitled *Given Freely: Volunteers in Canada*, "Albertans were the most likely of all Canadians to volunteer. During the reference year [November, 1986 - October 31, 1987] four out of ten persons (in Alberta) volunteered for an organization at least once." Statistics Canada estimated that 701,000 persons out of the Alberta's adult population of 1.8 million were classed as volunteers. It should be noted that the adult population is defined as those of us age 15 and over.

The following characteristics of Canadian volunteers were revealed in the survey results:

At 40%, Alberta's participation rate was higher than the rates in all other provinces. While it had 8.9% of the population aged 15 and over, it accounted for 13.1% of all volunteers in Canada.

Of the 701,000 Alberta volunteers, it was estimated that 393,000 females and 308,000 males volunteered. The participation rates were 44% and 35%, respectively.

Almost 6 in 10 volunteers were women.

In addition, half of all volunteers were in the 25 - 44 age group in Canada. More than 25% were between the ages of 45 - 64. Youths under 25 years of age accounted for 13% and seniors for about 11% of volunteers in Canada. Statistics Canada notes that the "rate of volunteering tends to increase with age, to a peak of 36% for 35 - 44 year old Canadians...and declines with advancing age to 22% for persons aged 65 years and over."

In terms of participation rates in major metropolitan areas, 38% of Edmontonians and Calgarians are listed as volunteers. Statistics Canada notes that the high rate for Calgary may be partly due to preparations for the Winter Olympics held in February 1988.

In terms of volunteers and marital status, nearly 3/4 of volunteers across Canada were married, but only 9% were widowed, separated or divorced. Married women accounted for a higher proportion of volunteers (39% versus 33% for married men). Twenty-three percent of single women volunteered versus 16% of single men.

That the participation rate of volunteers rises with education level. Although persons with a university degree are the most likely to volunteer, the greatest number of volunteers across Canada have high school education only (46%).

Statistics Canada also obtained household income estimates. The conclusion was that the likelihood of a person volunteering rises with a higher level of household income.

In terms of a volunteer's involvement in the labour market, it was determined that in the week preceding the survey, almost 2/3 of all volunteers in Canada were employed and about 1/3 were not in the labour force. Only 4% were unemployed.

On a Canada wide basis, almost half of the 9.2 million volunteer jobs were with religious organizations. Health, social services and service clubs accounted for an additional 2.6 million jobs.

The top three volunteer activities were fund raising, providing information, and organizing events.

Volunteers were attracted to the following organizations: religious, sports and recreation, education and youth development, health, and social services.

It is estimated that approximately 5.3 million volunteers contributed over 1 billion hours of their time during the reference year. On average, volunteers were each occupied 3.7 hours per week.

Survey Results for Alberta

In urban areas over 500,000 population, the number of volunteers as a percentage of a population is 38%, 37% for centres between 30,000 -100,000, 43% for centres 15,000 to 30,000 and 43% for small urban/rural areas.

The top organizations attracting volunteers in terms of participation were: education and youth development 18%; leisure, recreation and sport 17%; religion 16%; community society/public benefit 10%; health 9%; and social services care and support 9%.

Because of the small sample, it was very difficult to accurately determine the type of health organization that volunteers became involved in in Alberta. It would appear that the top two are "specific disease related organizations" and "hospitals/auxiliary hospitals."

With regard to the number of hours volunteered for health organizations in Alberta, the reliability of data only allows us to guess that volunteers in Alberta spend an average of about 8 hours per month on volunteer activities, or approximately 2 hours per week.

Estimates prepared by the Department of Community and Occupational Health in 1986 of the voluntary components of departmental programs revealed that for the 1986/87 fiscal year, it was estimated that the total dollar value of volunteer time for the four major departmental divisions was $17.6 million dollars, about 7% of the divisional budget in the same year.

Based upon the survey results prepared by Statistics Canada for the 1986/87 year, it is estimated that the 701,000 volunteers on average spent 8 hours per month for a total of 5,608,000 hours. At a rate of $10.00 per hour, volunteers in Alberta contributed $56 million in time per annum. Let's now assume the same volunteer rates for 1989/90.

These estimates are not exact. However, much of the Commission's discussions have centered around the valuable contribution that volunteers make to all sectors. These figures should convince us that volunteers contribute significantly to the health and concerns of all of us and some of us at the same time. The Commission hopes these efforts will continue to lead all Canadians in volunteerism into the next century.

APPENDIX XII
RECOGNITION OF ACHIEVEMENT AWARD WINNERS IN HEALTH

In Volume II Chapter 2, we talk about People: The Real Focus and our vision for the future. A glimpse of that future has been shown for many years in Alberta through Albertans demonstrating high standards of achievement in competition, voluntary service, and professional excellence. In 1969, the Achievement Awards Program was initiated to recognize these Albertans.

Because we are dealing with health, we believe it is important to re-emphasize the efforts of former Award winners in the health and related areas. People really do make the difference!

1972

	Area of Service
Cantor, Dr. Maxwell M.	Forensic Medicine
Weinlos, Dr. Harry	General Medicine
Stewart, Dr. Winnifred	Mentally Retarded Education
Vernon, Dr. Philip	Psychology
Weyant, Dr. Robert G.	Psychology

1973

	Area of Service
Moore, Alice	Mentally Handicapped Services
Millar, Lottie Rose	St. John's Ambulance

1974

	Area of Service
Adshead, Lawrence	Administration
Cameron, Donald Merlin	Chemistry
Mackenzie, Dr. W.C.	Education
O'Keefe, Gertrude	Nursing (Red Cross)
Weinstein, Dr. Frank	Podiatry

1975

	Area of Service
Leadley, Myrtle	Handicapped Services
Marlett, Nancy	Mental Health
Watson, Roy	Mentally Handicapped Services

1976

	Area of Service
Schaefer, Dr. Otto	Native Welfare
Perry, Pat	Blind
Macdonald, Alice	Blind
Macdonald, Alice	Blind - Braille
Bates, Walter O.	Handicapped
Lander, Dr. David	Medicine
Shandro, Tom	Physically Handicapped
Donald, Dr. W.A.J.	St. John's Ambulance
Erickson, Dr. Evan	Dentistry
Mckenzie, Dr. Walter	Education
Savin, Helen	Nursing
Tasker, Rachel	Support to Medicine
Giffen, Dr. John	Medicine - Various
Jackson, Dr. Mary	Medicine - Various
Jackson, Frank	Medicine - Various

1977

	Area of Service
Coombs, Walter	Mental Health
Fraser, Dr. Robert	Administration
Vant, Dr. Ross	Administration
James, Ted	Psychiatric Nursing
Wheatley, Marion	Nursing

1978

	Area of Service
Ross, Murray	Administration
Schumacher, Marguerite	Nursing
Shandro, Winnie	Nursing
Carnat, Dr. Morris	Psychiatry
Gilbert, Dr. Allen	Research (AADAC)
Hall, Dr. W.F.M.	Transport Safety
Smith, Dr. Stuart	Medicine - Various Organizations
Crawford, John	Blood Donations
Doyle, Kenneth	Blood Donations
Furnell, Donald	Blood Donations
Harris, Robert	Blood Donations
Kandborg, Gordon	Blood Donations
Kurth, Betty	Blood Donations
Macdonnell, Vincent	Blood Donations
Neufeld, Peter	Blood Donations
Offley, George	Blood Donations
Savell, Arthur	Blood Donations
Stephen, David	Blood Donations
Tomlinson, David	Blood Donations
Wylie, John	Blood Donations
Landsman, Pearl	Blood Donations

1979

	Area of Service
Buchanan, Dr. Donald	Blood Banks
Elliott, Frank	Education
Lesins, Dr. Karl	Genetics
Boldt, Menno	Mental Health
Thomson, Dr. Kenneth	Neurology
Tennant, Claudia	Nursing
Gans, David	Orthotics
Semple, John	Physiotherapy
Abt, Mary	Psychiatric Nursing
Nelson, Dr. Thomas	Psychology
Lakey, William	Urology
Nelson, Dr. Jean	Medicine - Various Organizations
Beedle, John	Blood Donations
Brown, James	Blood Donations
Campbell, Harold	Blood Donations
Harrison, Marshall	Blood Donations
Hinchliffe, Joseph	Blood Donations
Ross, Robert	Blood Donations
Bauer, Reverend Robert	Blood Donations
Mcpherson, Gary	Paraplegic Sports

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1980

	Area of Service
Young, Jim	Physically Handicapped
Macdonald, Dr. Neil	Medicine - Administration
Crouse, Dr. Dorothy	Clinical Psychology
Cooke, Dr. George	Medicine - General
Waddell, Boyd	Medical Photography
Crookshanks, Evelyn	Nursing
Harris, Margaret	Nursing
Sinclair, Rose	Psychiatric Nursing
Duggan, Dr. Hector	Radiology
Malle, Dr. Marshal	Radiology
Drummond, Dr. George	Biochemistry, Pharmacology
Jones, Katherine	C.N.I.B.
Patterson, Donald	C.N.I.B.
Lefort, Very Rev. Monsignor Joseph	Mental Health
Hewes, Bettie	Mentally Handicapped Services
Meikle, Dr. Christine	Mentally Retarded Services

1981

Wood, Dr. J.B.T.	General
Perdue, Elva	Infant Nutrition
Ebert, Beryl	Nursing
Parsons, Dr. William B.	Radiology
Ballantyne, Dr. Edwin E.	Veterinary
Brachman, Jerry	Blood Donations
Burke, Joseph	Blood Donations
Funk, Gilbert	Blood Donations
Hitzlberger, Eleanore	Blood Donations
La Fontaine, Stanley	Blood Donations
Leigh, Brian	Blood Donations
Pollon, Gordon	Blood Donations
Winchester, Violet	Blood Donations
Obermeyer, Winnie & Rudy	Foster Children
Backus, Dr. Barry	Medicine - Community Service
Robins, Esther	Nursing

1982

	Area of Service
Callaghan, Dr. John C.	Heart Research
Stinson, Dr. Shirley	Nursing
Scott, Doreen	Nursing (Mentally Ill)
Veale, Dr. Warren	Medical Research
Finnema, Everett	Blood Donations
Gagne, Grace	Blood Donations
Heslop, Matthew	Blood Donations
Illingworth, Brian	Blood Donations
Kociolek, Adam Casimir	Blood Donations
Mulawka, Russell	Blood Donations
Pon, Norman	Blood Donations
Rivard, Mervyn C.	Blood Donations
Smith, Eric	Blood Donations
Turton, Peter	Blood Donations
Whenham, Donald C.	Blood Donations
Wright, James	Blood Donations
Faider, Lily	Blood Donations
Gardner, Zoie	Foster Children
Laforge, Edna	Handicapped Services
Wilson, Daisy	Meals-on-Wheels
Paller, Gert	Medicine - Community Services
Berg, Mary	Mental Health
Allison, Flora	Nursing
Shillington, Ruby	Nursing
Staples, Dick	St. John's Ambulance
Webber, Pat	Community Service

1983

Schellenberg, John	Learning Disabilities
Ross, Dr. J. Donovan	Administration
Law, Gwen	Community Health Nursing
Richards, Dr. Len	Medicine - Various
Hatfield, Dr. Bob	Medicine - Various
Hatfield, Dr. Bruce	Medicine - Various
Weijer, Dr. Jan	Genetics
Hanna, M. Murray	C.N.I.B.
Hunter, Elizabeth	Environment
Maccagno, Thomas G.	Environment
Magee, Norman	Environment
Peacock, Edythe	First Aid
Reid, Isabell C.	Learning Disabilities
Shafto, Jean	Nursing
Johnson, Marion	Hearing Impaired

1984

Eriksen, Dr. Marla	Psychology
Maclean, Dr. Hector	Dentistry
Allin, Dr. Eardley	Medicine - Various
Kerr, Dr. Melville	Medicine - Various
Owen, Bill	Blind
Kinnear, Bill	Mental Health
Williams, Joan	Mental Health
Riddel, Jack	Multiple Sclerosis

1986

Seymour, Margaret (Gerry)	Nursing (Administration)
Herrero, Dr. Steve	Environmental
Weir, John	Handicapped
Flynn, Marlene	Learning Disabilities
Gregory, Lillian	Mental Health
Kemp, John (Jack)	Mental Health

1987

Ramsankar, Stephen Russell	Handicapped
McLeod, Dr. Lionel E.	Medicine - Administration
Mills, Karen	Nursing
Grisdale, Dr. Lloyd C.	Paediatrics
Gordey, Lorraine	Canadian Red Cross Society
Hadley, Gene	Canadian Red Cross Society
Macaskill, Jean C.	Environment
Zyp, Hank & Tillie	Underprivileged
Leask, Jim	Blind, Visually Impaired
Dunn, Janet	Handicapped Services
Way, G.J. (Jerry)	Handicapped Services

1988

Fitzgerald, Mary	Schizophrenia
Nelson, Dexter	Sport Therapist
Oliver, Gillian	Learning Disabilities
Kaplan, Dr. J. Gordon	Physiology
Longson, Gladys	Nursing
Hennig, George	Seniors & Handicapped Adults
Blair, Dr. David	Sciences — Medicine

APPENDIX XIII
GOVERNMENT OF ALBERTA HEALTH INITIATIVES 1979 - 1989

In preparation of this report, the Commission asked each Minister to provide a summary of the initiatives undertaken by the Government of Alberta since 1979 to improve the overall health of Albertans. A copy of each response is reproduced below by department or agency.

AGRICULTURE

Farm Safety Program — To enhance occupational health and safety on Alberta farms.

Protective Clothing for Pesticide Use — To inform pesticide handlers of how to reduce exposure to chemicals through the proper use of protective clothing.

Food Laboratory Services Branch — To provide support to the Alberta food and beverage industry in the areas of quality assurance, food safety and composition control.

Pasteurizer Testing Program — To ensure dairy product safety.

Dairy Processing Plant Inspections and Quality Monitoring — To ensure that dairy products are processed, packaged and stored in a satisfactory manner to ensure product safety.

Training and Licensing of Dairy Processing and Milk Handling Personnel — To ensure that key personnel involved in the transportation, grading, testing and processing of milk and milk products are aware of the importance of food handling procedures and recognition of potential risk factors.

Inhibitor Testing of Raw Milk — To ensure that all raw milk produced for sale in Alberta is free of inhibitor residues (antibiotics).

Dairy Farm Inspection Program — To ensure that milk is produced in a clean environment from healthy cows on farms that meet premises standards.

Raw Milk Quality Testing — To ensure that raw milk produced in Alberta complies with provincial regulatory standards.

Alberta Chicken Breeder Health Program and Alberta Turkey Breeder Health Program — To reduce hatching egg contamination at the farm level. The control of the entry of Salmonellae into the food chain is presently its major aspect.

Hatchery Sanitation Program — To reduce chick and poultry contamination at the hatchery level and to improve hatchery sanitation and chick and poultry quality. The control of the entry of Salmonellae into the food chain is presently its major aspect.

Pesticide Residue in Eggs Survey — To monitor commercial eggs for pesticide residues and chlorinated hydrocarbons.

Meat Inspection in Provincial Abattoirs — To ensure a safe and wholesome meat supply for the citizens of Alberta.

Safe Food Committee — To formulate policy to govern the collection of samples for surveys of pesticides, antibiotics, etc., in the food supply.

Pesticide Information — To enable users to make informed decisions regarding pesticide use.

Reference Source for Poison Centre — To provide information upon request to the Poison Centre operated from the Foothills Hospital in Calgary.

Water Analysis — To assist the development of the family farm and any agricultural industry by providing analysis of farm water supply.

Emergency Response to a Sour Gas Release — To respond to an uncontrolled release of sour gas; the laboratory carries out this mandate in providing a member to the Main Control Headquarters during a Category II Release.

Bacteriology Culture Services — To operate a Bacteriology Section, which performs isolation and culture techniques on all manner of bacteria.

The Designated Communicable Disease Regulation (Pursuant to the Livestock Diseases Act) — The main purposes of this regulation are: to minimize the public health hazard; to limit the spread within and to other herds/flocks; to resolve the problem on the farm; and to try to determine the source of the infection.

Central Rabies Control Committee — The purpose of this committee is to closely monitor and attempt to control rabies infection in both the wildlife and domestic animal populations in Alberta.

Foods and Nutrition Extension Program — To enable rural Albertans to select and prepare foods which foster health and well-being and, where possible, are grown and processed in Alberta.

Livestock Siting and Land Use Planning — To resolve regulatory inconsistencies between livestock siting guidelines and the Public Health Act.

Education Programs (Home Economics Branch) — To provide information in the form of news releases, fact sheets, publications and staff inservice education programs featuring appropriate eating habits and food selection, to help combat diseases such as heart disease, cancer, obesity, hypertension, and osteoporosis.

Food Processing Development Centre, Leduc — To assist Alberta food processors with the development of new products and modification of existing product lines; to assist them in meeting all established food safety regulations and advise them on proper quality control procedures.

ADVANCED EDUCATION

The Department of Advanced Education obtained $1.57 million in 1989/90 to address recommendations in the Commission's Interim Report. These funds are being used for the following program/projects:

Post-Basic Acute Care Nursing $779,500 — A new program was established at the Foothills Hospital and an existing program at the Misericordia Hospital was expanded. These changes created 94 new training spaces/year.

Post-Basic Gerontology/Long-Term Care Nursing $160,300 (est.) — Additional on-campus and distance delivery training capacity will be added so that currently employed nurses will have more opportunities to increase their knowledge and skills in long-term care nursing. (Final approval of programs is pending, based upon continuing discussions with Health about curriculum content).

Post-Basic Baccalaureate $561,000 — Approval has been granted for the existing programs at The University of Calgary and University of Lethbridge to be expanded by an overall total of 75 new spaces. Approval is pending on a new post-basic bachelor of nursing program at Athabasca University. The program will be aimed primarily at the needs of rural nurses and will graduate approximately 25 nurses annually by 1993.

Improved Integration Between Diploma and Baccalaureate Programs $100,000 — Funds have been provided to Calgary and Edmonton nursing educators to assist in the development of collaborative curriculum models that provide improved credit recognition and integrated program arrangements between the diploma and baccalaureate nursing programs.

The total expenditures exceed the $1.57 million special allocation due to additional funding provided within the department.

ENVIRONMENT

Air Quality

— increasing the sulphur recovery of small gas plants.
— reducing emissions of nitrous oxides through the use of clean-burn engines in compressor stations and some power plants.

Water Quality

— researching Giardia.
— researching in the Cold Lake area to protect aquifers.
— increasing treatment levels for drinking water, especially focussing on microbiological hazards such as Giardia.
— filtering shallow groundwater supplies before discharge.
— filtering and chemically treating surface water supplies before discharge.
— increasing effluent disinfection for major municipalities.

Wastes Disposal

— increasing standards on industrial discharges.
— eliminating discharges from some industrial plants.
— identifying, locating, and assessing, all industrial-landfills under Help End Landfill Pollution (H.E.L.P.).
— improving the management of underground storage tanks under Management of Underground Storage Tanks (M.U.S.T.).
— licensing pesticide applications.
— issuing permits for pesticide use.
— providing informational brochures on how to use pesticides.
— recycling paper, metal, glass, plastics, tires, white goods, and used oil.

Soil Protection

— improving regulations on soil protection.
— researching the land farming of municipal waste.

EDUCATION

School programs in Alberta support the principles presented in "Caring and Responsibility, A Statement of Social Policy for Alberta." The Alberta curriculum for grades 1 to 12 includes several compulsory (core) and optional (complementary) programs that assist students to develop the concepts, skills and positive attitudes essential for physical, emotional, mental and social well-being.

Health and Personal Life Skills Courses

All students must enroll in the elementary and junior high school health courses in grades 1 through 9. As a result of the secondary education policy, students who entered grade 10 in September 1988 are required to complete a new career and life management course (CALM 20) for three credits as part of the senior high school graduation requirements.

These programs contain themes that promote emotional and social well-being, positive interpersonal relationships, and physical well-being (nutrition, body systems, physical fitness, preventive drug and alcohol education, communicable diseases, safety and emergency procedures).

In addition, commencing in September 1989, all students will have access to a human sexuality program that commences in the grade 4 health program, and continues in the junior high health and personal life skills program and the senior high CALM 20 course. The provincial curriculum emphasizes a responsible decision-making approach to human sexuality and other health topics.

Physical Education Courses

The provincial physical education program is an important part of the schooling provided to help young Albertans improve their well-being. The program is to provide all students with the knowledge, skills, and positive attitudes that they need to lead active, healthy, productive lives, and to maintain a lifelong interest in physical fitness and recreational pursuits.

At present, physical education is a core or compulsory program for all students in elementary and junior high school. In senior high school, students must take a minimum of three credits in Physical Education 10 in order to obtain a high school diploma. In accordance with local needs and priorities, schools may also offer the Physical Education 10 course for four or five credits. In grades 11 and 12, students can enrol in additional complementary or optional physical education courses for credit toward a high school diploma.

The secondary physical education program comprises seven dimensions: aquatics, dance, fitness, games, gymnastics, individual activities, and outdoor pursuits. Comparable activities are provided at the elementary level. Teachers are to provide a well-balanced physical education course by selecting activities from each of these seven dimensions at levels appropriate to the abilities and aptitudes of their students. They are also to promote, where possible, school-community partnerships and to encourage students to become involved in extracurricular or after school recreational activities.

Optional (Complementary) Secondary Home Economics Courses

Optional junior and senior high home economics courses emphasize concepts, skills and attitudes that enhance personal and family living.

Other Program and Facility Directions That Promote Students' Well-Being

New programs are addressing health-related topics from a broader perspective. For example, the proposed junior high science program includes topics on microorganisms and food supplies (grade 7), consumer product testing (grade 8), and environmental quality (grade 9). The proposed senior high science program will also address health-related topics: body in balance and consumer product tests in Science 10 and human physiology in Biology 20.

Nutrition is one component of the new optional (complementary) program on agriculture for junior high students.

Safety and health are important components of all practical arts, physical education and science courses (eg. safety in laboratories, and in dealing with machines and equipment).

Funding has been provided to schools since 1984 for upgrading facilities to meet provincial code requirements relative to exhaust, lighting, air exchange and sound. Research has also been done to assess the impact of certain environmental factors (air, light, color) on students' well-being.

Government Health Policies and School Programs

School programs play an important role in government health policies. For example, schools are involved in the public education campaign on AIDS, "Education and Caring: Alberta's Program for AIDS" (October 1987). Through consultation with government agencies responsible for community health, support resources were identified for teachers and students, and an information bulletin was distributed to assist school jurisdictions in dealing with staff, students and other employees who may have AIDS. Some of the resources authorized for students and teachers were available free of charge to all junior and senior high schools.

The local health units and the Sexually Transmitted Disease Division provide inservice workshops to teachers, on request, to support the human sexuality components of the health and CALM 20 curricula.

Health personnel from various agencies were also involved in the development of the program and the review of resources for the health and CALM 20 curricula. Universities are offering courses that prepare teachers to provide instruction in these subject areas.

Parental, family and community involvement in school health programs is stressed and is an expectation of Alberta Education.

FAMILY AND SOCIAL SERVICES

Over the past ten years, Family and Social Services has undertaken many initiatives to improve the overall health of Albertans. These initiatives are in four major program areas: Child Welfare Services, Family Support Services, Income Support Services and Services to Persons with Disabilities.

Child Welfare Services

Program and services which address the overall health and well-being of children are provided through Child Welfare Services. Child Welfare Services focus on the provision of community based services to protect, enhance and support the development and functioning of children and their families.

The family is the basic unit of society and is essential to maintaining the health and well-being of children. Thus, the Foster Care program works to ensure the health of children who are in need of protective services, by providing a substitute family home.

Adoption services are offered by the Department to provide infants, older children, children with special needs and children who are wards of the province with a permanent and supportive parent(s) and family to ensure that they are provided with safe, nurturing relationships.

Recent initiatives by the Department have addressed the health and well-being of Native children, by ensuring that they maintain contact with their communities origin.

The Department ensures the survival, security and development of children by providing programs and services to children at risk, and to their families. These services include: investigation, apprehension, supervision, support agreements, custody/guardianship orders, group homes, residences and institution. All of these services are offered to support the well-being of children in the least intrusive alternative of care possible, and are provided wherever possible, within the context of the natural family.

Family Support Services

The Department's Office for the Prevention of Family Violence provides support and leadership in developing an effective approach to the problem of family violence in Alberta. The Office serves as a clearing house for information about family violence, develops educational material, provides consultation services and works with communities to develop initiatives to prevent family violence.

The Department's funding of Women's Shelters addresses the basic health needs of abused women and their children, as well as providing supportive services so that they can maintain both their mental and physical health in the future.

The Child Care Program supports the well-being of Alberta families by enabling parents to keep their children in quality child care while they are sick, working to support their families or pursuing their education. By making quality, affordable child care available, a number of families are kept out of poverty, and are able to supplement their family income.

Income Support Services

The Social Allowance and pension programs ensure that every person in need of assistance receives the goods and services that are essential for their health and well-being.

The programs are designed so that clients will be assisted in their efforts to gain or regain self-sufficiency and independence.

The income support programs enable adults and children in need to receive basic necessities.

Services to Persons with Disabilities

The Department works to ensure the well-being of families with handicapped children by providing them with funds for a variety of services that are delivered by community based groups. Handicapped Children's Services are designed to maintain handicapped children within the family home, or in as normal a community setting as possible.

The Department provides services which assist in the development, promotion and maintenance of a range of residential and support alternatives, that strengthen and maintain the self-sufficiency and well-being of Albertans with disabilities.

The range of services includes: group homes, approved homes, outreach services, relief services, supported living arrangements, vocational services and residential services.

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All of Family and Social Services' programs are designed to address the health and well-being of Albertans. Preventive services, such as child care or family violence prevention, are offered to ensure the health and well-being of Alberta families. Support services, such as those provided through income support or Handicapped Children's Services, enable families to remain together and attain the highest level of self-sufficiency possible. Other services and programs, such as Women's Shelters or group homes for persons with disabilities, improve the health of Albertans by providing emergency or long-term care in family-like settings.

HEALTH

Hospitals Division

Programs and Services

— Heart and lung/heart transplantations at the University of Alberta Hospitals.
— Major expansion in cardiac surgery and angioplasty procedures in the Holy Cross Hospital, Foothills Provincial General Hospital and the University of Alberta Hospitals.
— Approval and funding for expansion of programs in mental health and forensic medicine.
— Recent installations of extracorporeal shockwave lithotripsy at the Holy Cross and Misericordia Hospitals.
— Access to magnetic resonance imaging, CT scanners, and nuclear medicine equipment.
— Approval and funding for special care areas such as critical care, organ transplants, renal dialysis, cardiology and AIDS.
— Programs specific to the treatment of cancer such as: linear accelerators, simulators and a variety of cancer drugs.
— The introduction of a cost-sharing program and the use of lottery funds for high technology equipment.

Facilities

— From 1975 to 1988 development of 74 new and replacement health care facilities including the Walter C. Mackenzie Health Sciences Centre and the replacement of the Alberta Children's Provincial General Hospital.
— From 1975 to 1988 completion of major renovations or expansion in 46 facilities.
— Commitment to build a Northern Alberta Children's Hospital.

Special Program Areas

— Major review of Alberta's long-term care system resulting in initiatives such as single point of entry, the assessment/placement pilot project, expansion of long-term care beds and funding for long-term care service resource centres.
— Major review of Alberta's emergency health services and development of a new Ambulance Act.

Manpower

— 1988 announcement of 6 key initiatives to address employment concerns and increase educational opportunities for nursing disciplines.
— Development of the physician incentive program to encourage physicians to practice in rural areas.

Mental Health Division

— Development of a new Mental Health Act to broaden the rights of involuntary psychiatric patients.
— Development of a provincial suicide prevention program.
— Establishment of joint hospital/community mental health clinic programs (Venture, Spectrum).
— Support for community-based programs for the chronically mentally-ill such as the approved home program.
— Establishment of a permanent mental health promotion position within the Department.

Public Health Division

— New childhood immunization schedule is introduced.
— Implementation of the Hereditary Disease Identification program.
— Alberta Aids to Daily Living program is introduced.
— Implementation of a measles elimination program.
— Introduction of the hemophilus influenza vaccine to protect against meningitis.
— Introduction of the hepatitis B screening program to prevent infection in newborns.
— Expansion of speech pathology services throughout Alberta.
— Introduction of an early detection screening program for breast cancer.
— Expansion of sexuality education programs and sexually transmitted disease screening clinics.
— Classification of chlamydea as a reportable STD.
— STD clinical investigation unit is established.

Home Care

— Development of a client quality assurance program for home care programs.
— Funding increase of $10 million for expansion to home care programs.
— 44 per cent increase in home care funding from 1987 to 1989.

AIDS

— Strategic plan developed for the prevention and control of AIDS.
— $2.2 million toward AIDS communication program over 3 years, 1987 to 1988 - 1989 to 1990.
— Introduction of guidelines for dealing with persons with HIV/AIDS, 1989.

Health Care Insurance Plan

— Introduction of physical therapy as a basic health service under the Plan - 1981.
— End to extra-billing by physicians for medically required services -1986.
— Agreement reached for reciprocal billing of medical billings between provinces. January 1988 - B.C.; April 1988 - All provinces & territories except Quebec.

Promotion Activities

— 3-year TV campaign focusing on health promotion and illness prevention, 1987 to 1988 - 1989 to 1990.
— "Nobody's Perfect" TV program focusing on parenting education.
— "Baby's Best Chance" 13-week TV series in conjunction with the ACCESS network, 1987 - 1988.
— "Break Free" media campaign promoting non-smoking in youth, 1988.
— Alberta Heart Health Survey, to provide base data for future heart/ health promotion activities.
— Seniors' Wellness promotional campaign designed to promote positive use of leisure time for seniors.

LABOUR

Immigrants

— Licensing of immigrant physicians.
— Awareness of health care services.
— Physical disability as a protected category under the Individual Rights Protection Act.

General Safety Services

— The development and implementation of the B149 Natural and Propane Gas Installation Codes.
— Keeping industry abreast of code changes which are relevant to natural and propane gas plumbing and private sewage disposal systems, electrical wiring standards.
— Initiatives to lessen the risk of fire injury and premature death in the way of increased public education, in-school education programs, fire code enforcement, upgrading of building codes, increased fire fighting training.

Women's Issues

— Support of this department on the re-insuring of reproductive health services, i.e. vasectomies, tubal ligations, and the insertion of I.U.D.'s.
— The Alberta Women's Secretariat recently chaired an interdepartmental committee on new reproductive technologies.
— The Alberta Plan for Action for Women includes the promotion of preventive health care practices for women, the promotion of research and data collection, and the implementation of policies and programs to respond to women's reproductive health concerns.
— The Alberta Women's Secretariat Grant Program provides financial assistance for educational events relevant to health issues of concern to women.

RECREATION AND PARKS

The Ministry, which includes the Department of Recreation and Parks, Kananaskis Country, Alberta Sport Council and Recreation, Parks & Wildlife Foundation, has been recognized a leader in the promotion of active, healthy lifestyles for Albertans. This leadership role is demonstrated by the following programs, services and activities:

— The appointment of the first full-time staff member in Canada responsible for fitness development.
— The funding of Shape Up Alberta - a project administered through YMCA and provided fitness promotion services and activities to rural Albertans.
— The development and funding of the Be Fit for Life Centres located at community colleges throughout the province which provide leadership development courses, fitness testing and counselling, information dissemination and promotional activities.
— The creation and funding of the Provincial Fitness Resource Centre located at the University of Alberta which operates a model fitness testing centre, administers the Fitness Appraisal Certification and Accreditation program and a provincial resource centre on fitness and lifestyle programs.
— The establishment and support of certification programs for "on floor" fitness leaders and fitness appraisers/testers.
— The development and distribution of a variety of information including computer interactive resources on fitness development, leisure education and physical activity for specific target groups.
— The assistance to a wide variety of leadership development opportunities throughout the province.
— The management of the Alberta Come Alive project funded through Alberta Lotteries and operated through the Recreation, Parks & Wildlife Foundation and focussing on:

> — Major promotional activities to increase the awareness of the importance of active, healthy lifestyles in conjunction with Alberta Health; and a campaign to encourage Albertans to become more physically active.
> — Establishment of the Alberta Centre for Well-Being which will provide the focal point for networking and training on a multi-discipline basis, research and information dissemination activities; in addition to the development of initiatives for corporate wellness programs with a special emphasis on small business.

— Funding of special initiatives to enhance active, healthy lifestyles of Albertans such as Project Apex - a nutrition and fitness program for Grade Five students and a family recreation T.V. series in conjunction with the ACCESS Network.

— The funding of the construction and operation of indoor and outdoor facilities; and open spaces which allow a variety of participation opportunities, both structured and unstructured, for Albertans.

— The development and operation of provincial parks, recreation areas, wilderness areas and ecological reserves which allow the use, appreciation and protection of natural areas and the provision of outdoor recreation opportunities for Albertans.

— The participation in provincial, national and Federal/Provincial forums and activities such as heart health initiatives, standardization of leadership training, development of a national research agenda and the development of the Active Living Model which links physical activity and health.

These activities demonstrate the Ministry's commitment to improving the overall well-being of Albertans through Recreation and Parks programs and services. As presented in submission from the Ministry, Recreation has an important role to play in enhancing the health of Albertans. In conjunction with other agencies and organizations, Recreation and Parks is in a position to contribute in a significant way to the maintenance of high levels of health and well-being for Albertans and ultimately in assisting in controlling health care costs.

TECHNOLOGY, RESEARCH AND TELECOMMUNICATIONS

Directly addressing health care are two foundations that support basic and clinical medical research, the Alberta Heritage Foundation for Medical Research and the Alberta Foundation for Nursing Research. Through its support to science and technology development, the Department indirectly contributes to improving the availability of health care products to Albertans, most notably under the Medical Innovation Program.

An outline of these initiatives is given below.

Alberta Heritage Foundation for Medical Research

— Established in 1979 with a $300 million endowment to support a balanced long-term program of medical research and training in Alberta.

— As of 1987/88, the Foundation has awarded $250 million in direct funding to the Alberta medical research community.

— Focus of research is to answer basic biological questions about mechanisms of disease for improved diagnosis, treatment and prevention.

Alberta Foundation for Nursing Research

— Established in 1982 with a $1 million endowment for five years to support nursing research and the integration of research findings with nursing practices, education and administration.
— Extended in 1988 for five years at $200,000 funding per year (minimum).
— Focus of research is clinical practice: improving nursing care to patients in hospitals, elderly in nursing homes, families in community and others receiving nursing care.

Department

— Major initiative in technology transfer/ commercialization related to health care is the investment in Chembiomed (approximately $30 million) to commercially develop diagnostics and therapeutics based on research done at the University of Alberta.
— Support for medical research technology through general programs has included grants to local companies (SciCan Diagnostics, Synthetic Peptides Inc.) and University based research into protein structure and function, and herbal medicine biology.

TREASURY

Changes in consumption tax structure influence the behavior of consumers. Since 1982, tobacco taxes have been increased three times from .32 cents per cigarette in 1982, to 1.48 cents in 1983, to 4.0 cents in 1987, and to 4.8 cents in 1989. The reduction in tobacco consumption resulting from tobacco tax increases has contributed to improving the health of Albertans and reducing health care costs. The increases in tobacco taxes may also play a significant role in keeping young people out of the tobacco market.

SOLICITOR GENERAL

Correctional Centres

All Correctional Centres in the province have a contracted doctor and full time nursing staff to look after the health care needs of inmates. This involves the immediate identification and treatment of medical problems which were often left undiagnosed by the inmate when he/she was not incarcerated.

Mental Health

Specialized units to assess and treat mentally disturbed offenders have been developed and are in operation in Calgary and Fort Saskatchewan. Additionally "halfway houses" for mentally disturbed offenders are funded by the department in both Edmonton and Calgary.

Drivers

The introduction of the probationary driver's licence is working toward reducing the accident potential of new drivers in the province by monitoring the driving record and intervening, where required, with this high risk group. Additionally, more attention is focused on the problem driver generally to try and reduce the number of fatality and injury accidents.

Impaired Drivers

The department's impaired driving initiatives are designed to reduce the incidence of impaired driving and, as a result, also reduce the number of fatality and injury accidents. Some of the initiatives being undertaken include: a province-wide designated driver program; an impaired driving video which is mandatory viewing for all new drivers; production and distribution of "safe grad" material to all high schools; a hospital visitation program for high risk suspended drivers; year round "Checkstops" to detect and apprehend impaired drivers; and new legislation to substantially increase the penalties for impaired driving.

ACCESS NETWORK

Needs were met through the production and acquisition of video, audio, videodisc and print resources which were subsequently made available through both the Corporation's Media Resource Dubbing Centre and the television and radio broadcast services. Programs were co-produced with the following agencies:

— Alberta Professions and Occupations Bureau
— Calgary Health Services
— Occupational Health and Safety
— Alberta Alcohol and Drug Abuse Commission/Sturgeon Health Unit
— Huntington Society of Canada
— Muscular Dystrophy Association of Canada
— Alberta Law Foundation
— Canadian Cancer Society
— Canadian Public Health Association

The majority of these productions fall within the categories of Professional Health Care Education, Patient Education and Public Education. Examples include the following:

Professional Health Care Education

— Prevention: The Epidemiological Approach to Cancer
— Nursing Preceptorship
— Personal Care Aides
— Investigating Sudden Death
— Infection Control
— Nursing Assessment of the Infant
— Immunization By Injection
— Sterile Techniques
— Aero-Medical Transportation

Patient Education

— Duchenne Muscular Dystrophy
— Living with Cerebral Palsy
— Diabetes Care at Home
— Living with Huntington's Disease
— No Signature, No Shot

Public Education

— Smoking Against Your Will
— Cancer Prevention
— Baby's Best Chance
— Your Health
— Workers At Risk
— Medical/Legal Issues
— Action Options: Alcohol, Drugs and You
— Lifestyle Choices: Your Health, Baby's Health

ACCESS Network's commitment to health care programming is on-going. Currently, the Corporation is producing programs in such areas as issues in nursing, prenatal care, child safety, aging, first aid and training modules for Registered Nursing Assistants.

Programs Dedicated to Health Issues

— "Heritage for Health" produced in co-operation with the Alberta Heritage Foundation for Medical Research.
— "Health Support After the Headlines" a series produced in co-operation with a number of care-giving and support agencies.
— "Drugs - Friend or Enemy?" produced with the co-operation and financial assistance of the Alberta College of Physicians and Surgeons.
— "Ask an Alcoholic" produced in co-operation with the Alberta Alcohol and Drug Abuse Commission and Alcoholics Anonymous.
— "Coping in the Eighties" produced with the assistance of a number of government and community agencies providing health services to all age groups.
— "Recombinant DNA and Beyond" a series exploring scientific research and its application to medicine and health care delivery.

Features Devoted to Health Care

- — Family Matter
- — Something for Seniors
- — Scientists of Change
- — The Social Costs of Unemployment
- — Teen Waves

ACCESS Network CKUA Radio

Staff produced a major teaching component, comprised of over 10 hours of instructional tape, for the Alberta Vocational Centre to assist in the training of health care workers, and has produced a number of basic educational projects, i.e. "It's Up to You" and "All That I Can Be", supporting the Health curriculum for broadcast and classroom use.

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION

Over the past 10 years, Albertans have become more willing than ever to talk about the problems that stem from the abuse of alcohol and other drugs, and to seek assistance for the difficulties they are experiencing. To respond to their growing addictions needs, AADAC has progressively expanded the range of treatment and prevention programs it offers.

Changes over Past Decade

- — Six new outpatient counselling offices were opened, bringing to 22 the total number of communities with AADAC offices or facilities.
- — The Lander Centre, an inpatient treatment facility in Claresholm, was completed. In Grande Prairie, construction commenced on the Northern Addictions Centre. This will provide comprehensive treatment, and additional education and training opportunities, for Northern Alberta starting in October, 1990.
- — Funding for community agencies which provide addictions services increased substantially. By the 1988/89 fiscal year, a total of nearly $7 million was divided among 29 such agencies.
- — Several new specialized treatment programs began. IMPACT, an intensive weekend course for repeat impaired drivers, started in 1985. In 1989, a new province-wide treatment program for adolescents began operating.
- — A major alcohol and drug abuse prevention program for adolescents was initiated in 1981. This problem has contributed to marked reductions in alcohol and drug use among youth in the province.
- — The range of educational materials produced for the home, school and workplace greatly expanded. As well, AADAC staff responded to a growing number of requests from schools, community groups and professional organizations to organize and participate in prevention activities.

In these and its other endeavors, AADAC has continued to provide individuals and communities the support and encouragement they need as they strive towards healthier lifestyles.

APPENDIX XIII

ALBERTA HERITAGE FOUNDATION FOR MEDICAL RESEARCH

The Trustees and Council have regularly reaffirmed that the Foundation's programs and the evaluation of applications for funding should focus sharply on the quality and not the type of medical research. Medical research for the purposes of the Foundation was defined in very broad terms to include the full range of interests of health professionals and the sciences basic to medicine. Because of the paucity of applied research in Alberta and Canada, the Trustees, to add emphasis, have regularly reaffirmed their support for clinical and applied research. This affirmation is entirely in keeping with the Foundation's major objective: to develop a "balanced program" of medical research in Alberta.

Because national research granting agencies offer operating grants of all kinds, and because Alberta's major deficiency was, and in some disciplines continues to be, sufficient numbers of well trained adequately established scientists, the Foundation set as its primary task the training and recruitment of new scientists. These new scientists, if carefully selected, would be able to compete for external funds and increase the scope of medical research in Alberta. This would bring to our province a much augmented flow of research funds from external sources.

Funds for health care delivery and health care administrative research are not plentiful in Canada or elsewhere. This, however, has reflected, in part, the small number of skilled researchers in these disciplines. Growth in the numbers of well trained researchers and the sheer importance of the disciplines to health care cost utility studies should result in growth of funding.

From the outset, the university communities have been encouraged to seek out expertise in the full range of related disciplines. The Foundation now funds about 145 new scientists of whom roughly 60% are clinically qualified and engage not only in research but patient care and the education of health professionals. While many of these clinician scientists engage in basic research, most, if not all, pursue also applied and patient-based research. A few, too few as yet, are engaged in epidemiological and population-based research.

MULTICULTURAL COMMISSION

Through both the Alberta Multicultural Commission's Community Education Program and the Institute of Multicultural Resource Development we offer consultation and have developed programs for the private and public sectors to increase cultural awareness.

As our society becomes increasingly ethnically diverse, people such as health care professionals are faced with the unique challenge of acquiring knowledge and skills which are culturally intuitive and acceptable. It is our mandate to provide this cross-cultural knowledge and understanding so that the needs of a culturally diverse population can be met.

Initiatives

— Understanding Seniors and Culture - a publication to assist those working with seniors.
— Culture Makes a Difference - a one-day introductory program to improve skills required to work with staff or clients from diverse backgrounds. Participants have included health care providers.
— Distinguished Speakers Series - presentations by nationally and internationally established authorities. In June of 1988, Dr. Victor Kumar-Misir made presentations across Alberta on "Overcoming Barriers in Cross-cultural Health Care." The over two hundred participants included doctors, nurses, and other health care providers.
— On going Consultation - on a regular basis, institutions such as hospitals and senior citizen homes request assistance on incorporating multicultural programming within their institution.

ENVIRONMENT COUNCIL OF ALBERTA

The Council's major involvement in health issues has been through public hearing on related topics. Those with significant relationships to health issues are:

Hearings

— 1980 - Hazardous Waste Management in Alberta
— 1981 - 82 - Noise in Alberta
— 1986 - 87 - Recycling in Alberta
— 1985 - present - Alberta Conservation Strategy

Reports on topics such as: acid forming emissions, administration of the Clean Air and Clean Water Acts, environmental enforcement, the Canada Environmental Protection Act, environmental standards, and groundwater.

ECA's Volunteer Public Advisory Committees' Recent Activities

— A resolution in 1982 pointing out that farmers and health care professionals need to be better informed of the hazards of exposure to pesticides during their application. In response Alberta Agriculture established a program that was intended to deal with the Public Advisory Committee's concerns.
— A resolution in 1983 calling for public hearings on environmentally related human health concerns.
— A resolution in 1984 calling for auto emission standards in Canada to be at least as high as those in the U.S., especially nitrous oxide emissions, which adversely affect respiratory tissues.
— A review of issues surrounding indoor air pollution. Initiatives taken included development of a resolution in 1986 calling upon the Government of Alberta to designate an agency to establish standards and provide monitoring of indoor air pollutants in public and residential buildings and enforcing of indoor air quality standards in public buildings.
— A review of the health threat posed by burning of plastic pesticide containers led to a resolution in 1987 calling for used pesticide containers to be destroyed at the Swan Hills facility.

These activities led to an award from the Canadian Institute of Public Health Inspectors in 1988.

THE PREMIER'S COUNCIL ON THE STATUS OF PERSONS WITH DISABILITIES

In March 1987, during Rick Hansen's Man-In-Motion World Tour, a number of provincial groups and organizations representing disabled persons presented a brief to Premier Don Getty calling for the establishment of a body to:

- — advise the Provincial Government on policies and programs affecting persons with disabilities;
- — promote a greater awareness of the needs and abilities of persons with disabilities;
- — ensure consultation with disabled consumers and their advocates; and
- — promote coordinated programs and services with a consistent philosophy.

In May of 1988, with the proclamation of the Premier's Council on the Status of Persons with Disabilities Act, the government of this province recognized the need for a mandated, legislated approach to the promotion of "the opportunity for full and equal participation of persons with disabilities in the life of the province."

At the time of this report, the Council has been in operation for approximately one year. During that time, the Council has published a Vision paper entitled "Towards a New Vision of Abilities in Alberta", which proposes a new framework for policy development, and proposes five principles to guide it and government in the development of public policy. Following the endorsement of the Vision paper by the community and government, the Council will proceed with the development of an Action Plan, which will steer programs and policies affecting disabled persons into the 21st century.

APPENDIX XIII

THE WORKERS' COMPENSATION BOARD

— Provides cash and medical benefits to disabled workers, thus lessening the effect of industrial accidents and diseases.

— Over time, the extent of these benefits has expanded and the number of people covered by the Workers' Compensation Act has increased.

— Supports a more effective approach to health care through greater emphasis on accident reduction, early intervention, and interdisciplinary rehabilitation.

— Attention to these three issues lessens the impact of industrial accidents and diseases on both the individual and society, and improves the physical and psychological health of workers.

— During the last decade the Board provided over $387,000,000.00 in medical aid on behalf of workers.

— Provides considerable funding support for the administration of the Occupational Health and Safety Act.

— Involved in clinical medical research including development of expertise in Magnetic Resonance Imaging for diagnostic purposes and earlier recognition of disabilities.

— Helped underwrite the costs of a CT Scan and a University of Alberta research study entitled "A Functional Evaluation of Human Backs."

— Recently developed a special rehabilitation program for brain-damaged workers that reduces the overall impact of impairment.

— Emphasizes the early identification and management of occupational diseases and publishes papers on issues related to the medical aspects of workers' compensation and disability management. These assist preventive measures and suggest new forms of intervention.

— A strengthened commitment to rehabilitation over the last decade continues to be an important focus of the Board's activities.

— As mental and physical well-being are often tied to employment, the Board's focus on employment and rehabilitation contributes positively to overall health.

APPENDIX XIII

ALBERTA RESEARCH COUNCIL

The Alberta Research Council's current portfolio of programs includes many that have a direct effect on the physical and social health of Albertans. Of particular note is the Research Council's participation in an industry association known as Health Opportunities Alberta. Industry-driven proposals are expected to emanate from this group.

Recent and Current Projects at the Alberta Research Council Related to Health Technologies

A. Development of Medical Equipment and Materials

— Design and construction of a robotic work cell system for preparing various intravenous medications.
— Development of a test method for evaluating the durability of rubber gloves.
— Manufacturing techniques for titanium dental implants.
— Development of a fibre optics UV-visible near IR spectrometer to measure pollutants in effluents.
— Production and purification of high performance recombinant bio-materials for cosmetic and wound-dressing applications.

B. Development of Medications

— Project to exploit the branched-chain lipid system of bacteria to yield organisms of medical importance.
— Preparation by large scale fermentation of therapeutic enzymes used in extracorporeal medical devices.
— Preparation of Sangiunarine, a prophylactic orthodontal material.
— Preparation of medga-3-fatty acids from various cell cultures.
— Use of animal cell culture for the production and purification of bio-pharmaceuticals.
— Production of fish vaccines to reduce input of antibiotics to the food chain.
— Cultivation of fungi for the study of secondary metabolite antibiotics.

C. Development of Medical Diagnostics

— Medical expert system to aid the Medical Assistant in remote and isolated situations.
— Proposal to develop an expert system for nursing care, initially focussed on geriatric hypothermia.
— Expert system for the management of spills of hazardous materials.
— Elucidation of the biosynthetic path of branched-chain fatty acids which are major membrane lipids of many pathogens, including Anthrax, Legionella, Nocardia, Staphylococcus, Streptomyces and many others.
— Proposal for diagnostic reagent systems based on light-emitting technology.

D. Projects Related to Social and Environmental Health

— Expert system for water quality analysis.
— Proposal in preparation for a Safety Training van for the construction industry.
— Fault diagnostic artificial intelligence system for off-shore drilling rigs.
— Proposal for expert system for a suicide prevention training system.
— Assessment of photochemical models for application to hydrogen emission regulations related to acceptable ozone levels.
— Biosafety Program provides Alberta leadership position in health-related aspects of bulk bioprocessing.
— Participation in the "Bacterial Diseases" National Network.
— Establishment of the electronic Materials Safety Data Sheet (MSDS) data base, for access by Research Council staff.
— Proposal for an indoor environmental health program.
— Extensive analytical expertise, for example:
  — polynuclear aromatics in carbon black
  — isocyanates in paint
  — potential carcinogens in hydrocracker process water
  — contaminants in breathing oxygen
  — organic compounds in ground water.
— Environmental monitoring of fertilizers, plants and wood products to meet occupational health requirements.
— Development of procedures for incinerating hospital waste.
— Development of procedures for the deep disposal of liquid wastes.
— Development of a safety manual for investigators conducting field work.
— Development of a Corporate Wellness Program, emphasizing mental, physical and social health.
— Development of a pulp mill effluent treating system to remove suspended solids and to reduce toxicity.
— Characterization and treatment of oil and gas field waste sludges to permit safe disposal.
— High temperature electrolysis of hydrogen sulphide to produce hydrogen and sulphur.
— Testing of electromedical products for electromagnetic interference susceptibility.
— Geochemical distribution of potentially hazardous but naturally occurring substances, e.g., radon gas.

APPENDIX XIV
ALBERTA HEALTH CARE INSURANCE PLAN

Description

The Alberta Health Care Insurance Plan operates under the authority of the Alberta Health Care Insurance Act and the Health Insurance Premiums Act. It is a provincial government insurance plan which covers the cost of medical services and a number of related health care services for registered Alberta residents and their dependents.

Most employers arrange to register their employees and the employees' dependents through a group plan. All others, including people who are self-employed register by applying directly to Alberta Health Care.

Benefits

BASIC HEALTH SERVICES

Benefits are paid on a fee-for-service basis according to an approved schedule of benefits. Payments are made to registered residents of Alberta or, on their behalf, directly to practitioners. As of October 31, 1989 all Albertans registered with Alberta Health Care are entitled to the following:

— Medically-required services of physicians and osteopaths paid for under an approved schedule of fees.

— A number of specified oral surgical procedures carried out by a dental surgeon.

— Optometric services which consist of 3 benefits: a full eye examination (including refractions and the writing of a prescription for corrective lenses); a partial examination (including 2 or more single diagnostic procedures); and a single diagnostic procedure.

The three benefits are limited to: once each benefit year for children 18 years and younger, senior citizens and their dependents, and widows/widowers receiving the Alberta Widows' Pension and their dependents; once every 2 benefit years for all remaining Albertans aged 19 through 64 years.

The limits do not apply when the eye examination/procedure is medically required. Alberta Health Care does not pay for the fitting or the cost of glasses.

— Chiropractic services to a maximum of $12.40 for each visit, with a limit during each benefit year of $300.00 per person. The coverage includes $20.50 for X-rays for each particular disability.

— Podiatric services and appliances, paid for under an approved schedule of fees with a limit during each benefit year of $300.00 per person.

— Physical therapy services, paid for under an approved schedule of fees to a maximum of $20.20 per person per day, and with a limit during each benefit year of $300.00 per person.

The annual limits for physical therapy do not apply to persons eligible for Extended Health Benefits

(A benefit year runs from July 1st of one year through the following June 30th.)

NOT COVERED AS BASIC HEALTH SERVICES

— Health services not provided by or under the supervision of a practitioner entitled to charge for the service.

— Health services covered under a statute of any other province or territory or any statute of the Parliament of Canada.

— Any service determined "not medically required" by a physician, or classed as experimental.

— Patient or practitioner transportation costs.

— Charges for distance or travelling time of a practitioner.

— Advice given by telephone.

— Medical-legal services.

— Examinations required by a 3rd party for drivers' licenses (except as required by law for seniors just prior to 75th birthdate, and as required thereafter), employment, schools, summer camps, insurance or similar purposes.

— Routine dental care, dentures, eyeglasses, hearing aids, medical and surgical appliances and supplies.

— Drugs, plaster and special bandages.

— Services provided by a clinical psychologist.

APPENDIX XIV

EXTENDED HEALTH BENEFITS PROGRAM FOR SENIOR CITIZENS AND WIDOWS/WIDOWERS

If you or your spouse are 65 years of age or older, or if you are widowed aged 55 to 64 years and receiving the Alberta Widows' Pension, you and your dependents qualify for Extended Health Benefits.

These benefits cover dental care, eyeglasses, hearing aids, medical equipment, and medical and surgical appliances and supplies.

Details are outlined in the *Programs for Seniors* booklet available from the Senior Citizens Secretariat or from the Alberta Health Care Insurance Plan.

Basic Health Services Coverage As of October 1, 1989

	Monthly	**Quarterly**
Regular Premium Rates		
Single	$19.75	$59.25
Family	$39.50	$118.50
Subsidized Premium Rates		
Single Coverage		
Adjusted taxable balance not more than $3,500	Nil	Nil
Adjusted taxable balance above $3,500, but not more than $4,500	$6.50	$19.50
Adjusted taxable balance above $4,500 but not more than $5,500	$13.00	$39.00
Family Coverage		
Combined adjusted taxable balance not more than $6,000	Nil	Nil
Combined adjusted taxable balance above $6,000, but not more than $8,000	$13.00	$39.00
Combined adjusted taxable balance above $8,000 but not more than $10,000	$26.00	$78.00

ALBERTA HOSPITALIZATION BENEFITS

Alberta Hospitalization Benefits provide basic in-patient and out-patient hospital care for entitled residents of Alberta.

You are entitled to receive basic Alberta Hospitalization Benefits if you are an Alberta resident. A resident is a person who is lawfully entitled to be, or to remain, in Canada, and who makes his/her home and is ordinarily present in Alberta. This does not include tourists, transients or visitors to Alberta.

If you are entitled to receive benefits through another program or authority, such as the Workers' Compensation Board, you are not entitled to receive Alberta Hospitalization Benefits.

Hospitals in Alberta are divided into three classifications according to the type of care provided. Each type of hospital is included under Alberta Hospitalization Benefits.

General hospitals, often called active treatment hospitals, provide basic hospital services throughout the province. Specialist services are provided in larger, regional hospitals. Admission to a general hospital is by order of a physician.

Auxiliary hospitals provide care and treatment for patients with long-term or chronic illnesses. Admission to an auxiliary hospital requires a recommendation from the patient's physician to the Assessment Committee of the auxiliary hospital district.

Mental health hospitals provide psychiatric services to patients who are admitted by a physician. Acute care and long-term care are provided for adults. Special units are also available for the elderly.

Alberta Hospitalization Benefits provide coverage for the following in-patient and out-patient services in the province's approved general, mental health and auxiliary hospitals:

In-patient Services

— accommodation and meals at the standard or public ward level;
— necessary nursing care;
— diagnostic and treatment services;
— drugs, medical preparations and routine surgical supplies provided and administered in a hospital;
— transportation within the province between hospitals, and from a hospital to a nursing home when ordered by a physician; and
— special services as ordered by a physician, e.g. a private room.

You are entitled to stay in a hospital as long as your physician and the hospital's Utilization Committee consider your hospital treatment to be medically necessary.

Out-patient Services

— emergency treatment; and, where available — day surgery;
— diagnostic laboratory and radiological procedures;
— specialized clinics, such as orthopedic and diabetic clinics; and
— physical therapy, occupational, speech, respiratory and psychiatric therapy.

Alberta Hospitalization Benefits do not cover the following hospital services:
— private or semi-private room when provided at the request of the patient;
— transporting out-patients between hospitals;
— artificial limbs and other external prosthetic appliances;
— examinations for use by third parties (e.g. for insurance or employment purposes);
— drugs and medical preparations not considered necessary for treatment;
— oxygen for use by patients of auxiliary hospitals after discharge or when away from hospitals for weekends;
— drugs and other goods provided for use after a patient is discharged from hospital; and
— laboratory and X-ray services provided by a facility not approved by the Minister.

Patients requesting a private room will be charged for this service. Patients in a standard ward in an auxiliary hospital may be required to pay a daily fee.

Also, patients in a mental health hospital, who are not formal patients, may be charged a daily fee.

Supplementary health care coverage is available from private insurance companies, through employer groups at some places of employment, or through an individual or family contract. Consult your employer or insurance agent for this added protection.

Also, if you are unable to obtain additional coverage through an employer group plan, you may obtain Alberta Blue Cross coverage through the Alberta Health Care Insurance Plan, providing your premium payments are up to date. This Alberta Blue Cross Non-Group Insurance provides supplementary coverage at special rates for a number of health care services and needs, including ambulance services, prescribed drugs, appliances, home nursing, dental care needed as a result of accidental injury and the extra hospital charges for semi-private and private rooms.

THE ALBERTA NURSING HOME PLAN

Description

The Alberta Nursing Home Plan operates under the authority of The Nursing Homes Act. The Act provides for the establishment and incorporation of nursing home districts and gives the Minister of Health the authority to enter into contracts with district boards or proprietary agencies to provide nursing home care under the provisions of the Act.

Benefits

Nursing homes provide supervised, personal care for people who are not ill enough to require hospitalization in a general or auxiliary hospital but who require assistance in coping with daily living. There are three kinds of nursing home ownerships in Alberta — private, voluntary and district. Under the Alberta Nursing Home Plan, eligible residents receive per diem benefits in those homes which are under contract with the Minister to Health to provide care under the terms and provisions of The Nursing Homes Act. Each resident is also required to pay a daily rate set out in the regulations governing contract nursing homes. The daily rates that nursing home operators can charge directly to eligible patients stood at $14.00 for standard, $16.50 for semi-private and $20.25 for private accommodation.

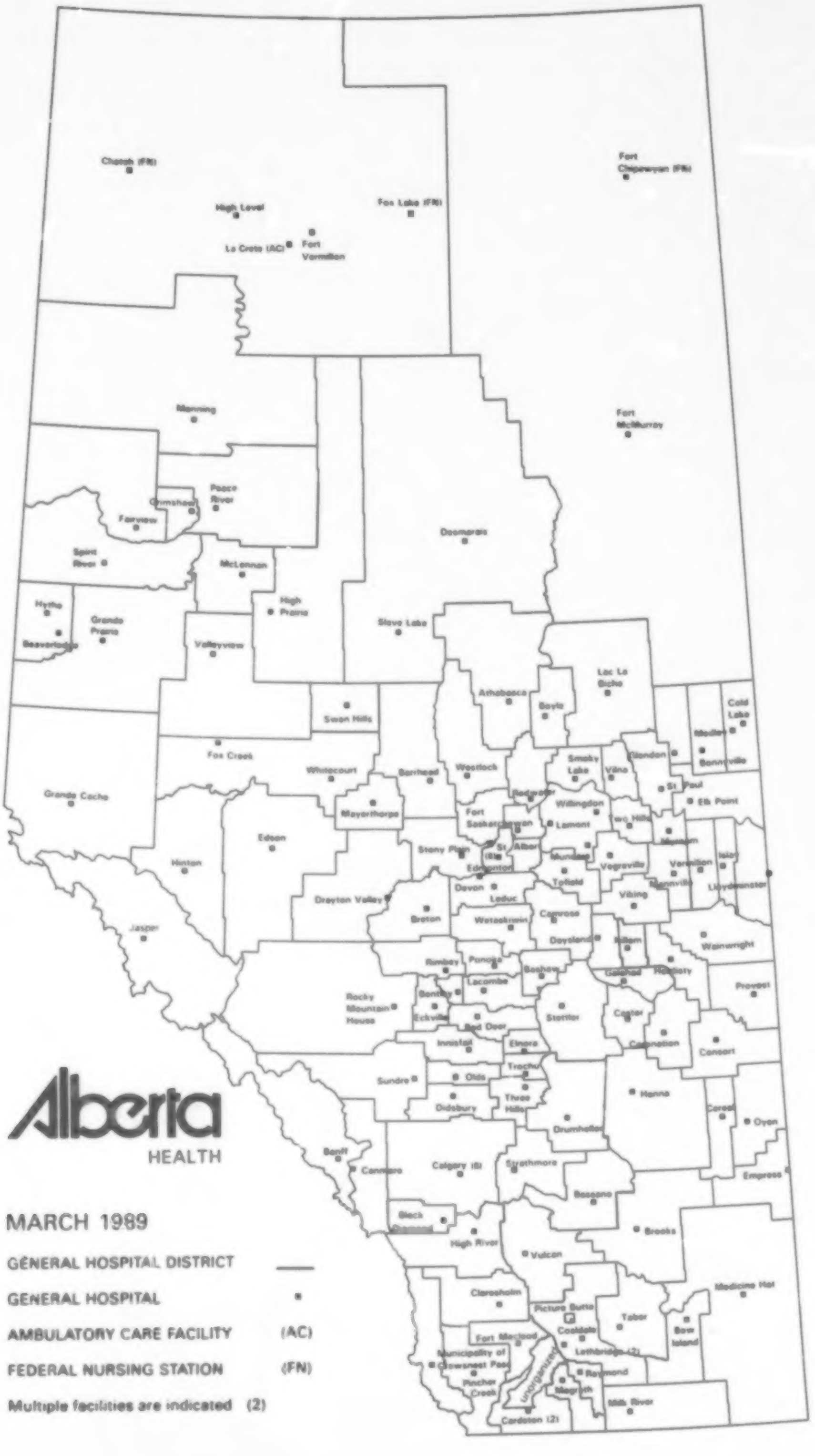
As of January 1990 there was a total capacity of 7,964 beds in 92 nursing homes, averaging 38.3 beds per 1,000 population 65 years of age and older.

APPENDIX XV
ALBERTA HEALTH ACTS AND REGULATIONS

Following is a list of acts and regulations under the jurisdiction of the Minister of Health.

- Alberta Health Care Insurance Act
  - Alberta Health Care Insurance Regulation
  - Assessment Committee Regulation
  - Chiropractic Benefits Regulation
  - Claims For Benefits Regulation
  - Dental Benefits Regulation
  - Extended Health Benefits Payable To Dental Surgeons Regulation
  - Extended Health Services by Dental Mechanics Benefits Regulation
  - Medical Benefits Regulations
  - Extended Health Benefits Payable to Ophthalmic Dispensers Regulation
  - Optometric Benefits Regulation
  - Extended Health Benefits Payable to Optometrists Regulation
  - Payment for Out of Province Medical Claims Regulation
  - Physical Therapy Benefits Regulation
  - Podiatric Benefits Regulation
  - Basic Health Service Benefits Payable to Dental Surgeons Regulation
- Alberta Hospital Association Act
- Alcohol and Drug Abuse Act
- Alcoholism and Drug Abuse Foundation Act
- Blind or Deaf Persons' Rights Act
  - Guide Dogs Qualifications Regulation
- The Calgary General Hospital Board Act
- Cancer Programs Act
  - The Cancer Regulations
- Change of Name Act
  - Change of Name Regulation
- Department of Health Act
  - Health Grants Regulation
- Lloydminster Hospital Act
  - Forms Regulation
- Dental Profession Act
  - Dental Profession Regulation
- Emergency Medical Aid Act
- Family and Community Support Services Act
  - Family and Community Support Services Regulation
- Health Facilities Review Committee Act
  - Rules of the Alberta Health Facilities Review Committee
- Health Insurance Premiums Act
  - Health Insurance Premiums Regulation
  - Penalty Regulation
- Hospitals Act
  - Alberta Hospitalizations Benefits Regulation
  - The Hospital Districts Regulations
  - Hospital Foundations Regulations
  - Operation of Approved Hospitals Regulation
- Human Tissue Gift Act
- Marriage Act
  - Marriage Act Regulation
- Medical Profession Act
  - Medical Profession By-Laws
  - By-laws of the College of Physicians and Surgeons
- Mental Health Act
  - Mental Health Regulations
  - Forms and Review Panel Regulation
  - Patient Advocate Regulation
- M.S.I. Foundation Act
- Nursing Homes Act
  - Nursing Homes General Regulation
  - Nursing Homes Operation Regulation
- Nursing Profession Act
  - Regulations Pursuant to the Nursing Profession Act
  - — Registration Regulation
  - — General Regulation
  - — Certified Graduate Nurse Regulation
  - — Code of Ethics Regulation
  - — Regulation and By-Law Approval Regulation
- Nursing Service Act
  - Regulations under the Nursing Service Act
- Optometry Profession Act
  - Optometry Profession General Regulation
  - Optometry Profession Standards of Practice
- Physical Therapy Profession Act
  - General Regulation
- Provincial General Hospitals Act
  - Hospital Foundations Regulation
- Public Health Act
  - Alberta Aids to Daily Living and Extended Health Benefits Regulation
  - Regulations Governing Barber Shops and Beauty Culture Parlors (Division 30)
  - Bodies of Deceased Persons Regulation
  - Communicable Diseases Regulation
  - Co-ordinated Home Care Regulation
  - Financial Administration Regulation
  - Food Regulation
  - Forms Regulation
  - Housing Regulation
  - Institutions Regulation, 1981
  - Provincial Board of Health Regulations Respecting the Keeping of Livestock and Poultry (Division 23)
  - Regulations Respecting Fluid Milk - Division 9
  - Provincial Board of Health Regulations Respecting Fluid Milk Standards (Division 33)
  - Nuisance and General Sanitation Regulation
  - Public Nomination Regulation
  - Qualifications of Inspectors Regulation
  - Recreation Area Regulation
  - Regulated Matter Regulation
  - Swimming Pool Regulation
  - Treatment Services Regulation
  - Waiver Regulations
  - Waste Management Regulation
  - Work Camps Regulation
- Radiological Technicians Act
  - Regulations under the Medical Radiological Technicians Board
- Registered Dietitians Act
  - General Regulation
- University of Alberta Hospitals Act
- University Hospitals Foundation Act
- Vital Statistics Act
  - Access to Information Regulation
  - Registration, Fees and Forms Regulation

APPENDIX XVI
ALBERTA HEALTH GENERAL HOSPITAL DISTRICT MAP


Chateh (FN)
High Level
Fox Lake (FN)
La Crete (AC)
Fort Vermilion
Fort Chipewyan (FN)
Manning
Fort McMurray
Peace River
Grimshaw
Fairview
Spirit River
McLennan
Desmarais
High Prairie
Hythe
Grande Prairie
Beaverlodge
Valleyview
Slave Lake
Lac La Biche
Athabasca
Boyle
Cold Lake
Swan Hills
Fox Creek
Whitecourt
Barrhead
Westlock
Smoky Lake
Vilna
Glendon
Medley
Bonnyville
St. Paul
Elk Point
Grande Cache
Redwater
Willingdon
Two Hills
Mayerthorpe
Fort Saskatchewan
Lamont
Myrnam
Edson
Stony Plain
St. Albert
Edmonton
Mundare
Vegreville
Vermilion
Islay
Hinton
Devon
Tofield
Mannville
Lloydminster
Leduc
Drayton Valley
Breton
Camrose
Viking
Jasper
Wetaskiwin
Daysland
Killam
Wainwright
Rimbey
Ponoka
Bashaw
Galahad
Hardisty
Provost
Lacombe
Bentley
Rocky Mountain House
Eckville
Red Deer
Stettler
Castor
Coronation
Consort
Innisfail
Elnora
Trochu
Sundre
Olds
Hanna
Three Hills
Didsbury
Drumheller
Oyen
Cereal
Banff
Canmore
Calgary (6)
Strathmore
Empress
Bassano
Black Diamond
High River
Brooks
Vulcan
Claresholm
Medicine Hat
Picture Butte
Taber
Fort Macleod
Coaldale
Bow Island
Municipality of Crowsnest Pass
Lethbridge (2)
Pincher Creek
Unorganized
Raymond
Magrath
Milk River
Cardston (2)

Alberta
HEALTH

MARCH 1989

GENERAL HOSPITAL DISTRICT	—
GENERAL HOSPITAL	▪
AMBULATORY CARE FACILITY	(AC)
FEDERAL NURSING STATION	(FN)
Multiple facilities are indicated	(2)

MATERIALS GUIDE

Purpose

The *Materials Guide* has been created to facilitate public access to the documents researched by and created by the Premier's Commission on Future Health Care for Albertans. It is also intended to serve as the Universal Bibliography to the Commission's Report.

Description

The *Materials Guide*, a separate publication, is a complete listing of all the materials used by the Commission in the fulfillment of its mandate to review the current system of health care in Alberta and to make recommendations for health care in the 21st Century.

The *Materials Guide* will be distributed to public, academic and health libraries throughout the province.

Location of Materials

Commission materials listed in the guide have been deposited with:

The Provincial Archives of Alberta
12845-102 Avenue
Edmonton, Alberta T5N 0M6
Telephone: 427-1750

and

Alberta Health
Library and Inquiry Services Branch
6th Floor, Donsdale Place
10709 Jasper Avenue
Edmonton, Alberta T5J 3N3
Telephone: 427-3530

Copies of the video cassettes made by the Commission are available from:

Provincial Film Library
2nd Floor, Queen's Printer Bldg.
11510 Kingsway Avenue
Edmonton, Alberta T5G 2Y5
Telephone: 427-4381

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Materials researched by the Commission are also available in various libraries throughout Canada.

Contents

Dispersal of the materials at the close of the Commission was determined in part by the format of the materials. A letter key accompanies each category below indicating that the material has been deposited with the Provincial Archives (A), Alberta Health (H) or the Provincial Film Library (F).

(A) *Submissions*

All submissions to the Commission from individuals or groups are available for examination, except those submissions that were offered with the request that they remain confidential.

(H) *Library Print Materials*

These materials consist primarily of books, journals, studies and reports.

(A) *Newspaper Clippings*

A file of photocopies of pertinent newspaper articles examined by the Commission is available.

(A,F) *Video Recordings*

Video cassettes were made of submissions at Commission-sponsored public hearings held in Edmonton and of some Town Hall Meetings.

(A) *Sound Recordings*

Conferences, seminars, workshops, etc. are recorded on audio cassettes as are portions of radio broadcasts concerning the Commission.

(A,H) *Working Papers*

In this category of materials are working papers produced by the Commission, unpublished papers used by the Commission, and recommendations of other provincial health commissions and committees.

(A) *Administration Files*

Certain files generated by the Commission pertain directly to the Report. Among them are Acts & Legislation, Committees, Conferences, Public Relations and Workshops.

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Copies of the Commission's newsletters are available at no charge from the Queen's Printer Bookstores in Edmonton and Calgary.

Copies of the video tapes of all organizations' presentations at the Public Hearings held in Edmonton are available from the Provincial Film Library.

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